

If the environment is right...



things can go wrong

and acute cystitis can result.

Urine can act as a culture medium for the growth of *E. coli* and other organisms.¹ When urine is contaminated, bacterial proliferation is influenced by several factors—rate of urine flow, frequency of voiding, volume of residual urine and antibacterial action of the bladder mucosa.² When the concentration of bacteria builds to a high enough level in the urine, acute cystitis usually develops.

Gantanol® (sulfamethoxazole) for early, decisive control

Early, aggressive therapy with Gantanol (sulfamethoxazole) may control acute, nonobstructed cystitis due to *E. coli* and other susceptible gram-negative and gram-positive organisms commonly implicated in urinary tract infections, and thus help prevent chronic or ascending infection.

rapid, long-lasting antibacterial levels

Peak therapeutic effectiveness starts within 2 to 3 hours of the initial 2-Gm adult dose. Each subsequent 1-Gm dose maintains therapeutic blood and urine levels up to 12 hours.

prompt clinical response

Significant symptomatic improvement of acute cystitis often occurs within 24 to 48 hours after the start of Gantanol therapy. In fact, symptoms may subside so rapidly that it is important to emphasize that patients continue medication until treatment is adequate. The usual precautions in sulfonamide therapy should be observed, including maintenance of adequate fluid intake.

your option: tablets or suspension

Gantanol comes in two b.i.d. dosage forms providing around-the-clock therapy—tablets or pleasant-tasting, cherry-flavored suspension. Either way, Gantanol is effective, convenient and economical therapy in non-obstructed urinary tract infections caused by susceptible organisms.

References: 1. Asscher, A. W., Sussman, M., and Weiser, R. *Urol. Dig.*, 7: (422, 1968); 2. O'Grady, R., and Cartell, W. R. *Brit. J. Urol.*, 38:156, 1966.

Before prescribing, please consult complete product information, a summary of which follows.

Indications: Effective in acute, recurrent or chronic urinary tract infections (primarily pyelocystitis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) and in the absence of obstructive uropathy or foreign bodies. Note: Carefully coordinate in vitro sulfonamide sensitivity tests with bacteriologic and clinical responses. Add antimicrobial acid to culture media of patients receiving sulfonamides. Resistant organisms present a current problem to the usefulness of antibacterial agents. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Sulfonamide hypersensitivity; infants less than 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis); pregnancy at term and during nursing period.

Warnings: Safe use in pregnancy has not been established, and teratogenicity potential has not been thoroughly investigated. Sulfonamides will not eradicate or prevent sequelae to group A streptococcal infections, i.e., rheumatic fever, glomerulonephritis. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; early clinical signs such as sore throat, fever, pallor, purpura or jaundice may indicate serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination are recommended frequently during sulfonamide therapy. Clinical data are insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate deficiency.

right for acute, nonobstructed cystitis

Gantanol® B.I.D. (sulfamethoxazole)

Tablets/Suspension
12 hours of therapy with every dose

diagnosis should not be delayed. In the latter, central hemolysis may occur. Maintain adequate intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias: agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; allergic reactions: erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, serum sickness, puritus, urticaria, angioedema, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitivity, arthralgia and allergic myocarditis; gastrointestinal reactions: nausea, emesis, abdominal pain, loose stools, diarrhea, anorexia, pancreatitis and stomatitis; C.N.S. reactions: headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, vertigo and insomnia; and miscellaneous reactions: drug fever, chills, toxic nephrosis with oliguria and anuria, perianitis nodosa and L.E. phenomenon. Due to certain chemical similarities some sulfonylureas, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of sulfonylurea diabetes and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age, except adjunctively with pyrimethamine in congenital toxoplasmosis. Usual dosage is as follows:

Adults: 2 Gm (4 tabs or teasp.) initially, then 1 Gm b.i.d. or t.i.d. depending on severity of infection.
Children: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, followed by 0.25 Gm (20 lbs b.i.d.). Maximum dose for children should not exceed 75 mg/kg/24 hrs.

Supplied: Each tablet or teaspoonful (5 ml) suspension contains 0.5 Gm sulfamethoxazole.

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

New 'Tonar' Device Aids Measurement and Therapy in Severe Nasality: Page 9

U.S. and Soviet Agree to Pool Research Efforts in Major Health Areas: Page 16

Stories of Interest in Pediatrics: pgs. 2, 16, 20, 21; in Psychiatry: pgs. 1, 8, 11, 20

Medical Tribune

and Medical News

world news of medicine and its practice—fast, accurate, complete

Wednesday, March 1, 1972
Vol. 13, No. 9

A Psychiatrist Is Successful In Home Visits

Medical Tribune Report

ATLANTA, GA.—An Atlanta psychiatrist reports that he has obtained "dramatic therapeutic results" by visiting or living in the homes of his patients—for a few hours or a few days—and he believes that other psychiatrists should consider making more home visits.

Dr. Alfred A. Messer has found that he can learn much more about a family, its pattern of living, and its methods of coping with stress by going into a patient's home than he can by interviewing the patient and members of his family in an office.

"I actually move in with some patients for periods ranging up to three days," Dr. Messer said. "This home-living, which I began about a year ago, is valuable both as a research tool and as a method of treatment. It has enabled me to learn a great deal about the lives of patients and to help them work out some of their problems."

Dr. Messer

A research psychiatrist at Northside Community Mental Health Center here, Dr. Messer has taught psychiatry at Emory University and Columbia University, and he is board-certified in psychoanalysis as well as in psychiatry. He is a visiting professor at the Medical College of Georgia.

Dr. Messer regards "home-living" by psychiatrists as a natural extension of the current medical trend toward "moving out of the plush office suites on the 12th floor of a modern building into communities where better health care is needed."

"Medicine today is moving into ghettos, remote neighborhoods, and rural areas," Dr. Messer pointed out. "This is part of a decentralization trend."

"Periodically, there's an outcry about doctors' not wanting to make house calls. To me, it makes more sense for a psychiatrist to make house calls than for any other specialist. A patient with pneumonia needs treatment oriented primarily to his

Continued on page 16

Drug Agencies Are Asked For Study Approval Data

Medical Tribune Report

WASHINGTON—A Congressional subcommittee has called on the Bureau of Narcotics and Dangerous Drugs and on the Food and Drug Administration to make public how long it takes a scientist to get approval for a bona fide research project with a classified drug.

Voicing "concern" over charges by leading investigators that the BNDD's red tape has hampered research with psychotropic drugs and made it difficult to obtain needed compounds, Rep. Paul G. Rogers (D-Fla.), chairman of the Subcommittee on Public Health and Environment, ordered the bureau to prepare "for the record" how it has gone about processing research applications. He called for a similar account from the FDA.

Prehistory Man Studied



At the University of Alabama, Dr. Albert Casey shows common skull measurements he performed on the early Shell-Menden people. Results were compared with skulls from other regions.

Mr. Rogers said at subcommittee hearings on drug abuse that the delays experienced by medical scientists appeared to be "getting a little out of hand."

He told BNDD director John E. Ieger.

Continued on page 18

Vein Bypass Grafts Certain Cases With Angina May Be Helped

Medical Tribune Report

CARMEL, CALIF.—Experience to date at the Stanford University School of Medicine suggests that there may be a group of patients with unstable angina who can benefit from saphenous vein bypass surgery despite the high surgical mortality, a meeting of the Western Society for Clinical Research was told here.

Early study and careful selection for surgery of individual patients with impending myocardial infarction is indicated, according to Drs. David S. Cennom, John S. Schroeder, Alfred P. Spivack, and Donald C. Harrison, of the school's cardiology division.

Substantial improvement or elimination of angina was experienced by 22 patients who underwent surgery and survived, but five others did not survive surgery, they reported. Follow-up data were not available for one other patient who survived.

The type of surgery performed varied considerably, but the majority of the patients had at least two saphenous vein grafts, and no patient had associated resection of ventricular muscle or valvular replacement.

There were no late surgical deaths and no immediate postoperative infarctions. After an average follow-up period of seven months, 18 patients were completely free of angina and had resumed their prehospitalization activities and four patients reported substantial subjective improvement in their exercise tolerance but were still experiencing occasional, if less frequent,

Continued on page 18

Medicoeconomics

Hospital Association Speeds Toward Health Leadership

Medical Tribune Report

WASHINGTON—The momentum appeared to be gathering rapidly at the annual meeting of the American Hospital Association here for the A.H.A. to become the leading spokesman in the nation's health care concern.

Implicit in this movement, although seldom stated, is a head-on confrontation for spokesmanship with the American Medical Association, which thinks of itself as representing "organized medicine."

Partly in an effort to become the main voice in health care, the A.H.A. is attempting to broaden the representation on its councils and suggested that "experts and interested citizens" could well be admitted "to the highest policy-making levels, including the Board [of Trustees] itself."

One concrete expression of the broadening influence came in the first report from the A.H.A.'s new National Committee on Health. Its chairman, Nelson A. Cruikshank, who also is president of the

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Study Links Myasthenia, Immune Cause

Medical Tribune Report

TORONTO—An immunologic etiology for myasthenia gravis, which has often been suspected but never proved, moved a step closer to possibility in a report here by investigators at the University of Toronto.

In vitro, at least, they told the Canadian Society for Clinical Investigation, the thymic lymphocytes from MG patients show signs of being sensitized to human muscle tissue while thymic lymphocytes from normal subjects do not.

Thymic lymphocytes are those that emerge from the thymus gland to become the agents of cell-mediated immunity.

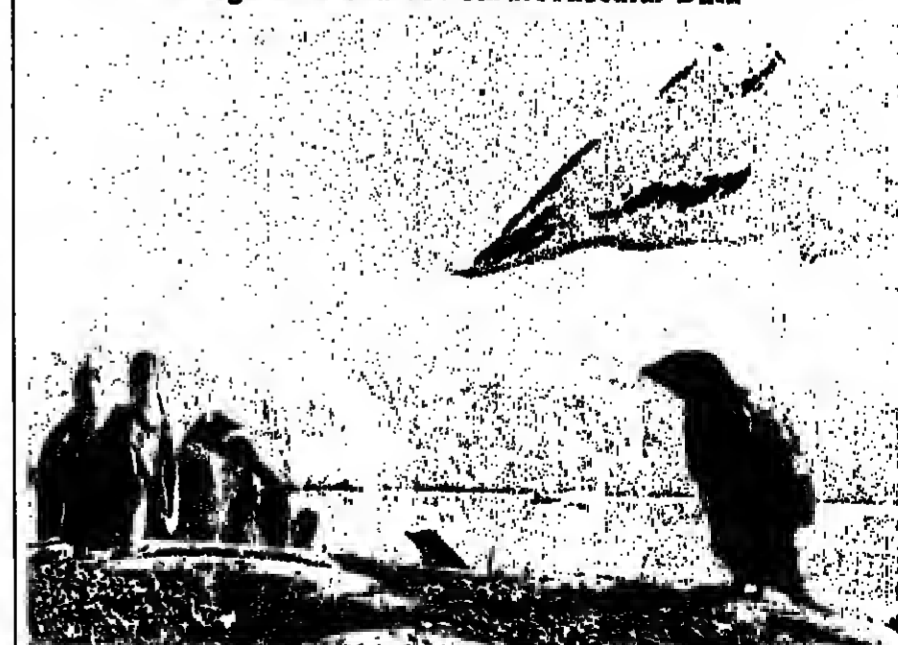
While this immune response may be a primary defense against malignancy, it also is the one that most imperils organ transplants and presumably is at the heart of autoimmune diseases.

Myasthenia gravis has long been postulated but never established as an autoimmune disease. Dr. Richard M. Armstrong said in an interview here. The work by him and associates at University of Toronto does not establish it either, he said, but "we see strong suggestions of a cell-mediated immune response to muscle antigens."

Their investigation employed thymic

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Penguins Broadcast Cardiovascular Data



Cardiovascular adjustments of penguins during exercise and other data have been gathered by University of Washington scientists Kjell Johnson, Ph.D., Ron Millard, Ph.D., and graduate student Bill Milson. Operating from Palmer Station, 700 miles from the South Pole, they collected data using catheters and electrodes. Aided by the American Heart Association, program may aid studies of human heart disease.

1970 Hepatitis Epidemic in Japan Laid to Children's Tuberculin Test

Medical Tribune World Service
From the Japanese Edition

TOBA CITY, JAPAN—Tuberculin tests of children in the elementary and secondary schools of this town have been identified as the cause of an explosive epidemic of serum hepatitis in 1970. The outbreak was the first mass epidemic of the disease ever recorded in Japan.

The epidemic occurred between the end of April and the beginning of July and affected 15 per cent of all the children in the elementary school and 43 per cent of those on the secondary school. Other age groups were virtually unaffected, but a high rate of Australia antigen was discovered both in patients and in healthy children.

The development and course of the epidemic were analyzed by Dr. R. Mizuta, of the Department of Pediatrics of the Yamada Red Cross Hospital.

Outbreak Was on Island

The region where the outbreak occurred is a solitary offshore island 2.5 miles from the center of Toba City that is divided into three settlements—Ijika, Motoura, and Imaura.

In May a seven-year-old boy complained of fever, nausea, and jaundice and was sent to the Yamada Red Cross Hospital Pediatrics Department. Nine days later a 10-year-old girl patient complained of jaundice and general fatigue and was admitted to the hospital. Later six children of the same school were admitted to hospital with hepatitis.

On June 5 it seemed that the epidemic in schools had come to an end. In early July, however, there was an explosive epidemic in the middle schools. A total of 129 patients were sent to Yamada Hospital, 94 of whom were suffering from hepatitis as illustrated by liver function tests.

Pakistani Drive Aims to Raise Life Expectancy in Generation

Medical Tribune World Service

KARACHI—A drive has begun to increase life expectancy in Pakistan to 60 years within a generation, bring down the child mortality to 7.5 per thousand, and eradicate such diseases as tuberculosis and malaria. The plan, which will also provide for a health unit dispensary or hospital for every group of 5,000-10,000 inhabitants in the nation, was announced here by Dr. Mubashir Hasan, Pakistan's minister for finance, economic affairs, and development.

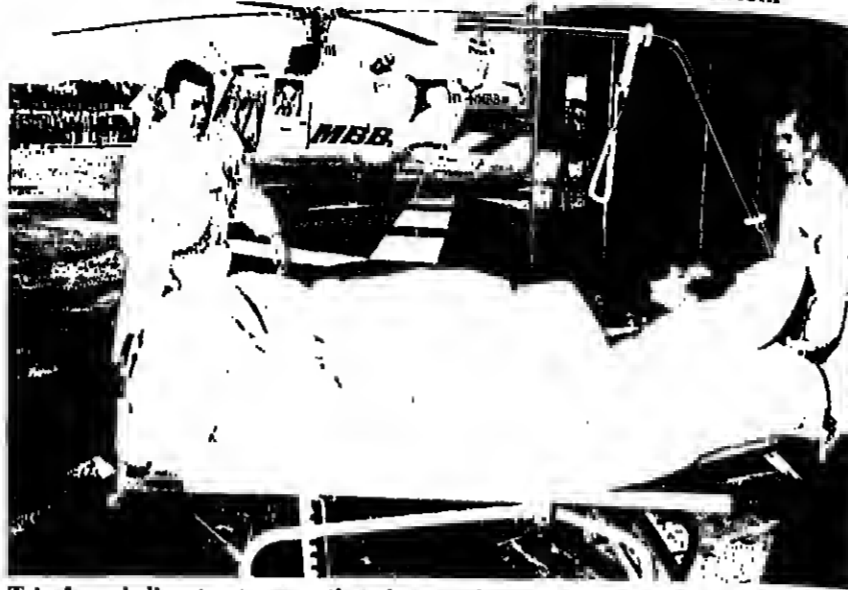
Addressing officials of the national planning commission here, he also targeted an increase in the daily per capita intake of calories.

Objectives that he said should be established immediately include proper housing for Pakistan's 26,000,000. "At present only about 3,000,000 are adequately housed," said the minister.

NEWS INDEX

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German Clinic Solves Outdoor Space Problem



Trip from helicopter to opening theater via transporter requires less than a mile

Munich Hospital Begins Copter Landings on Roof

Medical Tribune World Service
From the West German Edition

WIERSBAEEN, WEST GERMANY—The Rienecker Clinic in Munich is the first German hospital to lay out a helicopter landing site on its roof. The decision was made because of the lack of space around the clinic—it is situated in a residential area on the outskirts of Munich—and the desire to reduce noise. The first test landings showed that disturbance due to engine

noise was substantially lower than a nearby heliport.

The problem of exhaust gases is solved by landing on the hospital since the turbine exhaust can be drawn in by the air-conditioning plant, the operating theaters and intensive care units. The roof landing site is so constructed that bed patients can in no way be endangered in the event of an accident.

The patient transporter on the roof is kept clear during the landings and is wheeled out only afterwards. The patient reaches the operating theater in one minute.

Sensitive, Rapid Test Measures Desoxycorticosterone Levels

Medical Tribune World Service

ROME, ITALY—A sensitive and rapid radioimmunoassay for measuring plasma desoxycorticosterone (DOC) levels has been developed. Dr. Franco Mantero reported here at the fifth meeting of the International Study Group for Steroid Hormones.

Dr. Mantero, of the Medical Sematology Institute, University of Padua, said that results obtained with the new test appeared to be slightly lower than plasma concentrations calculated from the secretion rate and metabolic clearance rate and in good agreement with the DOC levels measured in adrenal vein plasma by the double isotope method. "For specificity, sensitivity, and rapidity, this method will be useful in dynamic studies," he said.

Assay Developed Jointly

The radioimmunoassay, which is of particular interest for researchers working on problems of hypertension, was developed jointly by Dr. Mantero and Dr. Edward G. Bifulco, of the University of California and San Francisco General Hospital clinical study center.

Dr. Mantero said that in developing the assay a steroid protein conjugate was obtained by coupling DOC 21-monosuccinate to rabbit gamma globulin.

One milligram of this preparation in complete Freund's adjuvant was injected into rabbits at repeated intervals. At the

end of six months the rabbits produced an antiserum that reacted significantly with DOC and progesterone and, to a lower degree, with testosterone (20 per cent) and 17-OH-progesterone (7 per cent). "No significant cross reaction was found with all the other steroids tested, including 11-desoxycortisol, corticosterone, cortisol, cortisone, aldosterone, and androstosterone," he said.

Vietnam Plague Cases Account For Nearly 1/2 World's '71 Rate

Medical Tribune World Service

GENEVA—Vietnam is still the country worst affected by plague. In 1970 there were 421 reported cases, almost half the global figure for the year.

This total does not include 3,635 suspected cases of the disease, resulting in 59 deaths, that were never confirmed by laboratory examination.

Released plague incidence figures for the past 10 years, the World Health Organization here pointed to an increase in the disease in the U.S. mainly in the Rocky Mountain states. Fifty-three cases have been reported there since 1950. WHO sees a possible link with the increase in outdoor camping.

Approximately 20,000 cases of plague, with 1,516 deaths, were reported to WHO during the period 1961-70. The graph

started to rise from 1965 onwards, mainly reflecting the situation in Vietnam, WHO noted.

In 1970 there were 852 cases with 16 deaths, reported throughout the world, a majority in Asia. For the first time in many years, Europe had a case of bubonic plague. In 1970 a case was imported to France from Bombay.

An International Reference Center for Plague has been established at the Swiss Union's Central Institute for Research in Plague Control at Alma Ata.

Environment Data to Be Tracked

Medical Tribune World Service

TOKYO—The Japanese Government plans to develop the exchange of information to develop the exchange of information with the U.S., Britain, France, and other countries. A new department of the Japanese Environment Agency has been set up.

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Scans Studied In Thrombosis And Embolism

Medical Tribune Report

CHICAGO—A study of brain scanning in the differential diagnosis of cerebrovascular accidents indicates that patients whose stroke is secondary to cerebral thrombosis will have persistent negative scans, regardless of the interval between the stroke and the scan, while those whose stroke is secondary to cerebral embolism will have a positive scan several days after but not on the day of the stroke, it was reported here by a team of Pittsburgh investigators.

The study, which included 213 patients admitted to the intensive care stroke unit of St. Francis General Hospital, was initiated in December, 1966, in an attempt to establish the etiology of the stroke in each patient, the investigators told the 57th annual meeting of the Radiological Society of North America, Inc. "Our purpose," they said, "was to determine, if possible, whether the stroke was secondary to a cerebral thrombosis or to a cerebral embolism."

Following routine physical and laboratory examinations, a brain scan was done on each patient as soon as clinically feasible. A second scan was obtained to approximately 10 days. Five views of the brain were obtained and independently studied by two observers.

Patients' Status Determined

One of the investigators determined the status of the patients on admission and, after pertinent data were recorded, decided whether the stroke was secondary to a cerebral thrombosis or cerebral embolism. Eighty-three of the patients were considered to have had a cerebral embolism and 130 a cerebral thrombosis, according to the scanning criteria.

The results indicated that in those with a cerebral embolism, scans taken on the first day of the stroke or within the first two days will be normal. Subsequently, the scan becomes positive, "and in our series, 76 patients out of 83 suspected of having a cerebral embolism were found to be positive by day 20," the investigators noted. The remaining seven patients were scanned at various intervals after their stroke, with the longest interval 280 days. "It is presumed," they said, "that if these

Angina Patients Said to Be Guarded By Clofibrate Against Sudden Death

From British Edition

LONDON—Clofibrate appears to protect angina patients against the risk of myocardial infarcts and particularly against the risk of sudden death.

That is the major finding of a five-year trial of clofibrate carried out on two large groups of patients in Scotland and in New Zealand upon Tyne. A total of 1,214 patients were treated.

The drug did not appear to protect patients with a history of previous infarction but with no history of angina.

And the protective effect in angina patients bore no relation to the drug's action in lowering cholesterol levels.

ECTOPIC BEAT

If anyone is interested, the March 10 meeting of the Society for the Scientific Study of Sex is presenting the following program: "Eros in the White House: Sexual Concerns of some Presidents." Speaker: Milton Pleasure, Ph.D. Sometimes the White House seems to us a little more on the Thanatos side. (Regular beats Immature Media, Page 23.)

ECG Processed



COMPU-GRAM, a new technique for long-distance computer processing of ECGs, is being demonstrated by nurse at Mount Sinai Medical Center, New York. Patient, returned within two hours, includes analysis of cardiac rhythm and contour. Thirty hospitals are now connected to the program.

patients had been scanned within the first 20 days after their stroke, the scans would have been positive at that time." They noted that after day five, no normal scans were obtained.

The study, they said, did not conclusively determine how long a brain scan will remain positive after a cerebral embolism, but they reported one patient with a persistent positive scan eight months after his stroke without any suspicion of an intervening stroke to account for the positiveness of the scan at that late date.

Patients suspected of having had a cerebral thrombosis had negative scans throughout their hospital stay.

"To explain why embolism and not thrombosis produces a positive brain scan, we postulate that a sudden occlusion as in cerebral embolism causes such a shock to the brain tissue that a capillary reaction results in an attempt to save the brain," they said. "In patients with a stroke secondary to a thrombosis, the event is a gradual affair, and while the complete shut off does produce symptoms of a stroke, the area of brain supplied has made a gradual adjustment to a diminishing blood supply and the mechanism producing capillary proliferation and macrophage appearance does not occur."

Authors of the report were Drs. John D. McAllister, Joseph DiPrimio, Joseph E. Tuttle, and Ronald A. D'Alto and Maureen L. Henry.

Palliative Approach Aids In Esophagus Carcinoma

Medical Tribune Report

SAN FRANCISCO—A palliative approach to epidermoid carcinoma of the esophagus has improved the quality of life "immeasurably" in 21 patients without any reduction in survival, according to a team from the University of Maryland School of Medicine.

Physicians there adopted a "philosophy of palliation" in the face of a marked failure of attempts to cure the disease, combined with an unacceptable morbidity associated with these attempts, the Society for Thoracic Surgeons was told by Dr. John R. Hankins.

Since irradiation produces long-term survival and good palliation in upper-third and cervical lesions, this became the primary mode of therapy for this group, while resection became the primary mode of treatment for middle- and lower-third lesions, he said.

Since the new approach was adopted, hospitalization time has been reduced, the patients are able to swallow and maintain hydration and nutrition, respiratory infection from aspiration is unusual, fistulas have not occurred, and gastrostomy is unnecessary, the surgeon said.

In addition, he declared, "many are not sacrificed to have a few." This referred to the fact that there were only six survivors among 234 patients treated in the previous 11 years by curative resection, irradiation, or both at the University of Maryland Hospital. Among these patients, "the morbidity, as indicated by fistula formation and the necessity to perform gastrostomy, was significant and unacceptable in terms of patient comfort and survival," he said.

Of the 21 patients treated palliatively, four had upper-third lesions. Two were irradiated and are alive seven and eight months, respectively, following treatment and are clinically free of disease, and their swallowing ability is excellent.

The other two had extensive disease, and subtotal colon bypass procedures were carried out. Both died three months after resection, but prior to their deaths swallowing was much improved over the preoperative status, Dr. Hankins said.

No Operative Deaths

Esophagogastricomy was performed on 11 patients with middle third lesions, and there were no operative deaths. Six of the patients are alive after two to 15 months, and five died after three to 13 months. Swallowing ability was "excellent" in 10 patients and in one other reached this status after dilatation. Dr. Hankins reported.

All the six patients with lower-third lesions were operated on, and five were resected. Of the resected patients, three are alive at two, four, and 22 months, respectively. Two died at three and 27 months. "Excellent" palliation was achieved in all the resected patients.

There was no operative mortality among the 21 patients, Dr. Hankins emphasized.

In conclusion, the surgeon remarked that "one may be critical of this [palliative] approach, but only if it could be demonstrated that such treatment does not cure most of those curable by more radical means. Such is not the case. Long-term survival and cure are possible by irradiation therapy in upper-third and cervical lesions and by standard esophagogastricomy in lower-third lesions. So far as middle-third lesions are concerned, cure by any means is so rare that the argument is voided."

"Palliation is the most important consideration until such time that definitive measures for cure are discovered."

Coauthors of the report were Drs. Fred N. Cole, Anne Ward, Edward A. Carter, Seymour Weiner, and Joseph S. McLaughlin.

Combined Therapy Eases Plight of 88 In Hodgkin's Series

Medical Tribune Report

ST. LOUIS—Eighty-eight of 146 patients with stage 3 and 4 Hodgkin's disease achieved a complete remission with a combination of nitrogen mustard, vincristine, procarbazine, and prednisone (MOPP) given as monthly courses for six months. It was reported here by a team of investigators from the Mountain States Tumor Institute, Boise, Idaho, and the M. D. Anderson Hospital and Tumor Institute, Houston, Tex.

The remission rate of the patients, who were treated by members of the Southwest Cancer Chemotherapy Study Group, was the same for male and female patients and did not vary greatly with age, although it was slightly but not statistically lower in those over 59 years. The investigators told a symposium sponsored by the Cancer Clinical Investigation Review Committee of the National Cancer Institute.

Furthermore, it was reported, the remission rate was the same for stages 3A, 3B, and 4A disease, ranging from 75 to 79 per cent. There was a lower rate, 51 per cent, for patients with stage 4B disease—that is, with both node and organ impairment, as well as symptoms of fever, night sweats, and/or pruritus.

Prior Therapy Influential

The remission rate, it was noted, was influenced by prior therapy: 71 patients with little or no prior therapy had a rate of 76 per cent, compared with only 45 per cent in 75 patients who had major prior therapy with either radiotherapy, chemotherapy, or both.

Thirty-five patients who achieved complete remission were maintained with MOPP courses given every two months; 33 had treatment discontinued after either six or two courses, respectively, after complete remission was attained, the investigators reported.

Maintenance treatment favorably influenced the duration of remission, they said, noting that median duration for the maintained patients was about 180 weeks, compared with 85 weeks for the unmaintained patients.

Among maintained patients, it was found that prior therapy influenced the duration of remission: those with no or minor prior therapy had a median duration of 233 weeks compared with 113 weeks for those with major prior therapy, either radiotherapy, chemotherapy, or both. Duration of remission was approximately the same, however, for patients in complete remission and not maintained on MOPP.

The investigators are Drs. James K. Lucas and Emil Frei III, Edmund S. Gehan, Ph.D., and Fred Dalenay.

COMING NEXT ISSUE

- Inotropic agents**
Antiarrhythmic effect may be beneficial in heart failure.
- Asthmatic children**
Theophylline therapy brings decrease in symptoms.
- Heroin addiction**
Canadian urges development of effective antagonists.



It may be just a mild depression. But she needs help...and needs it right now. Counsel and reassurance may suffice. But if you decide supportive medication is indicated, Ritalin can

offer prompt benefit. No need to wait days or weeks to begin feeling better. Ritalin improves mood and outlook, helps the patient get moving again.

Ritalin is generally well tolerated, even by older or convalescent patients. And there's generally no need for long-term therapy. When Ritalin works, one prescription may be sufficient.

Ritalin

(methylphenidate)

helps overcome the inertia of mild depression

Ritalin® hydrochloride (methylphenidate hydrochloride) TABLETS

INDICATIONS

- Mild depression.
- Minimal brain dysfunction in children (often manifested in the form of hyperkinetic behavior), as an aid to general management.
- Drug-induced lethargy produced by the quillins, barbiturates, anticholinergics, anticonvulsants.
- Apathetic or withdrawn senile behavior.
- Narcolepsy.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug or in patients with glaucoma.

WARNINGS

Ritalin should not be used for severe depression of either exogenous or endogenous origin.

Because it may mask normal fatigue due to overexertion, Ritalin should not be used to increase mental or physical capacities beyond physiological limits. Use cautiously in patients with hypertension and in patients with a history of seizures, since it may lower the convulsive threshold.

Ritalin is not recommended for children under six years, since safety and efficacy in this age group have not been established.

Drug Interactions

Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenytoin, and triethylcyclohexylamine (phenytoin, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

The safe use of this drug in pregnant women during lactation has not been established. Therefore, the benefits must be weighed against the potential hazards.

Animal studies using low dosages in pregnant females have revealed no adverse effects on reproduction.

Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, particularly those with a history of drug dependence (including alcoholism), since such patients may increase their dose on their own initiative. Chronically abusive use can lead to tolerance and psychic dependence with varying degrees of abnormal behavior. Psychotic episodes can occur, especially with prolonged abuse. Careful supervision is required during drug withdrawal for severe depression as well as the risk of chronic overactivity can be minimized. Long-term follow-up may be required to ensure the basic personality disturbances are relieved.

PRECAUTIONS

Patients with an element of agitation may react adversely; continued therapy is necessary.

Periodic CBC and platelet counts are advised during prolonged therapy. Long-term therapy of Ritalin in children should be accompanied by repeated medical follow-up including appropriate laboratory tests.

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other adverse reactions: hypersensitivity reactions, anorexia, nausea, dizziness, palpitations, headache, dyskinetic, drowsiness, skin rash. Blood pressure and pulse change both up and down, may occur; tachycardia may be observed more frequently in children than in adults. A few instances of arrhythmia and cardiac arrhythmias have occurred. Abdominal pain and weight loss during prolonged therapy have been reported and may occur more frequently in children.

DOSEAGE AND ADMINISTRATION

Administer orally in divided doses 2 or 3 times daily, preferably 30 to 45 minutes before meals. Dosage will depend upon indication and individual response.

Average dosage is 20 to 30 mg daily. Some patients may require 40 to 60 mg daily. In others, 10 to 15 mg daily will be adequate. The few patients who are unable to sleep if medication is taken late in the day should take the last dose before 6 p.m.

In children with minimal brain dysfunction as an aid in general management, start with small doses (e.g., 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. Paradoxical aggravation of symptoms or other adverse effects are indications to reduce dosage or, if necessary, to discontinue the drug.

HOW SUPPLIED

Tablets, 20 mg (pale yellow); bottles of 100 and 1000.

Tablets, 10 mg (pale green); bottles of 100, 500, 1000 and Sip Dispensers of 100.

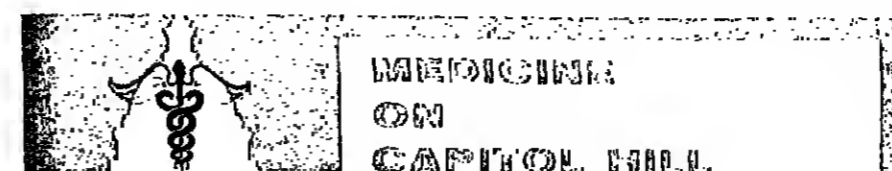
Tablets, 5 mg (pale yellow); bottles of 100, 500 and 1000.

Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

Wednesday, March 1, 1972

MEDICAL TRAINING



By WILLIAM ROY, M.D.
Congressman from Kansas

OFTEN, when I was campaigning last year, a person would come up and say, "Why are you running for Congress? We are so short of doctors, and you are doing so much that is worth while in your present profession. If you win, we will be short one more doctor."

The question was usually asked seriously and deserved then and deserves now a serious answer. It is apparent that I believed before election that I could be of greater service to the people of northeast Kansas and our country as a member of Congress.

I greatly enjoyed medical practice. I liked and admired nearly all of my colleagues, especially the two fine men with whom I had practiced for 15 and six years, respectively.

Am I really of more service in my public capacity than I was as a physician? Today, after almost a year "on Capitol Hill" as the United States Representative from the Second District of Kansas, I can say with assurance that the answer to that question is in the affirmative.

I have been impressed by the quality of most of the men and women serving in Congress. Their education and abilities would make them accomplished leaders in any field. But the job of Representative is so great and so demanding that few can measure up in every way—and too frequently we do not measure up collectively. Some excellent, progressive legislation has been defeated by a coalition of people of differing philosophies attacking for often opposite reasons. This is frustrating—for veteran Congressmen as well as for freshmen.

Equally frustrating is the inability to get a "handle" on more than a fraction of the legislation and legislative needs. Time and staff do not permit.

But there have been and are great satisfactions. One great source of satisfaction is the privilege of serving on the only committee and subcommittee for which I am especially prepared—the Public Health and Environment Subcommittee of the Interstate and Foreign Commerce Committee. Our chairman, Paul Rogers of Florida, is held in uniformly high regard in the House and has the energy and political savvy, as well as knowledge of his field, possibly unequalled and certainly not surpassed in the House. Because of Paul, our committee can achieve significant legislation. Because

of the quality of the men on the subcommittee, prominent among whom is our fellow physician, Dr. Tim Lee Carter of Kentucky, the legislation is certain to be well studied and likely to reach the goals envisioned.

THE ACHIEVEMENT of needed, significant health legislation is my primary satisfaction. Without this and the continuing opportunity to affect world peace, I would return to medical practice. As you may ascertain from the words above, this job has higher highs and lower lows. And the life of a practicing physician was much easier and materially more rewarding for me and my family.

One piece of legislation that answers the "one less doctor" question is the Comprehensive Manpower Training Act and Nurse Training Act, recently signed by President Nixon. If these acts are fully

funded, there will be no shortage of doctors and nurses in 1980. However, there is some doubt that adequate funding will be forthcoming. We recently passed the Cancer Act, which will launch the greatest effort to conquer a disease in the history of mankind. Legislation to combat the tragic national drug problem will be out of committee soon.

Because we are facing perhaps as much as a decade of health care legislation and because I believe many physicians have special insights to people problems and human behavior, I would encourage more of my medical colleagues to become my Congressional colleagues. Congress has long been dominated by attorneys (301 of 435 House members); we need a better cross section of the population.

In this series of columns I will be giving you one physician's viewpoint of what is happening "on Capitol Hill." Nearly everything that happens here will affect your life and our profession. I am especially interested in the organization of medical care delivery—a subject we all know something about—and the critical element in achieving quality health care for all of our citizens. I look forward to our exchange of information, and I hope that my interpretation of legislative matters will be helpful to you.

In Sterile Environment



Wearing rubber gloves, nurse Eileen Kneiser attends three-month-old baby with lymphocytic hypogammaglobulinemia from birth. Neonate was delivered and has been living under totally sterile conditions. Physicians at the General Clinical Research Center, Texas Children's Hospital, are attempting to induce antibody production in child. Clinic is supported by the Division of Research Resources at NIH.

A gratifying announcement about Emprin® Compound with Codeine

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Emprin Compound with Codeine
relieves aches,
pains, fever and
general malaise
of colds and of



Calif. Law Fights Cancer Quackery

SACRAMENTO, CALIF.—"Savings to the pocketbooks of cancer patients in California who are protected from quack therapy may be in the range of \$50,000,000 to \$100,000,000 annually," according to a report from the State Department of Public Health recently submitted to the State Legislature.

"Diversion of money spent for worthless treatment to useful purposes enables families to better withstand the drain on the family pocketbook and prevents untold suffering from failure to receive proper treatment in sufficient time to be life-saving," it added.

The report, prepared by the fraud section of the Department's Bureau of Food and Drug, said strict enforcement of California's tough cancer quackery laws will continue in 1972, in order "to detect those violators who are responsible for the death and debauchery of the unsuspecting, hopeful cancer victims."

The report said persons suffering from cancer, or believing they have cancer and dreading surgery or radiation treatment, are ready victims of those who say they need not suffer from the disease.

You may now specify up to five refills within six months when you prescribe Emprin Compound with Codeine (unless restricted by state law).

It is significant in this era of increased regulation, that Emprin Compound with Codeine has been placed in a less restrictive category. You may now wish to consider Emprin with Codeine even more frequently for its predictable analgesia in acute or protracted pain of moderate to severe intensity.

Emprin Compound with Codeine No. 3 contains codeine phosphate* (32.4 mg.) gr. ½. No. 4 contains codeine phosphate* (64.8 mg.) gr. 1. (Warning—may be habit-forming.) Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.

Librium® dosage options: as versatile (chlordiazepoxide HCl)

Librium has demonstrated its effectiveness in relieving clinically significant anxiety associated with a wide range of emotional and somatic problems.

for the geriatric patient
with clinically significant anxiety



Librium® 5 mg
(chlordiazepoxide HCl)
initially b.i.d. or less
up to 20 mg daily

Librium is used concomitantly with certain specific types of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is a clinically significant factor.

Librium, because of its wide margin of safety, is especially well suited for extended use until the patient can perform at appropriate levels without it. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.) Moreover, the antianxiety benefits of Librium are generally maintained without diminution of effect or need for increase in dosage. When treatment is prolonged, periodic blood counts and liver function tests are advisable until antianxiety medication is no longer required.

Three oral strengths plus an injectable form permit therapy to be adjusted to individual needs until antianxiety medication is no longer required.

for moderate
anxiety as in many cardiac patients



Librium® 10 mg
(chlordiazepoxide HCl)
1 capsule t.i.d./q.i.d.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions:
ORAL: In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or over-sedation, increasing gradually as needed and tolerated. Not recommended in children under six.

as anxiety problems are varied

for the patient with severe anxiety



Librium® 25 mg
(chlordiazepoxide HCl)
up to 100 mg daily

INJECTABLE: Keep patients under observation, preferably in bed, up to three hours after initial injection; forbid ambulatory patients to operate vehicle following injection; do not administer to patients in shock or comatose states; use reduced dosage (usually 25 to 50 mg) for the elderly or debilitated and for children age twelve or older.

ORAL AND INJECTABLE: Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating compounds such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation,

for the acutely agitated chronic alcoholic



Injectable Librium®
(chlordiazepoxide HCl)
100-mg ampuls
up to 300 mg
if indicated

extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

With the injectable form, isolated instances of hypotension, tachycardia and blurred vision have been reported; also hypotension associated with spinal anesthesia, and pain following I.M. injection.

Supplied: Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Ampula containing 100 mg chlordiazepoxide HCl.

ROCHE Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Doctors' Debate

MEDICAL TRIBUNE frequently receives extensive and well-documented communications from physicians on current subjects of controversy or those of great current medical interest. We invite contributions in these areas for presentation in this new feature.

Reorientation in Diabetes

Editor, MEDICAL TRIBUNE:

Even though currently indispensable, the basic discoveries of Withering, Jenner, Semmelweis, and others were made without the benefit of statistics (and, *horrible dictum*, without double-blind studies or animal experiments and such). And, while results by statistical methods are thought to be unequivocal, it is yet possible for two eminent statisticians, leaning on identical facts, to arrive at antithetical results.

In a recent issue of the *J.A.M.A.* (September 20, 1971), the one (Stanley Schor) rejects, while the other (Jerome Cornfield) accepts, the conclusions of the University Group Diabetes Program—namely, that the combination of diet and tolbutamide is no more effective than diet alone in prolonging life and that the findings suggest that tolbutamide and diet may be less effective than diet alone or than diet and insulin.

Since statistics are seemingly indispen-

sable in some but not in all periods of human history and since the results are most often but—as shown by Schor and Cornfield—not always unequivocal, it follows that the method is not the supreme court from which decisions in all disputes can be expected. To avoid being bogged down, it may be sometimes necessary to take a giant step and to look for help beyond statistics.

In the metastatistical world the credibility of a finding is reinforced if a reasonable interpretation of the mechanism is supplied. With this in mind, when the cause of the high mortality rate in the tolbutamide group remained, in spite of a serious search, obscure to the investigators, I offered an interpretation. The interpretation was based on observations which were reported some time ago—namely, that the blood pressure rises in hypertensive diabetics when the blood sugar drops and vice versa (Foldes, Eugene: "Diabetes and Hypertension,"

Amer. Journ. Med. 3:145, 1947, and Foldes, Eugene: "Hypertension in Diabetics," *J.A.M.A.* 202:845, 1967).

Accordingly, following the rules of homeostasis, glands are pouring increased amounts of hormones into the circulation when the composition of the blood shifts in a direction opposite to the effect of the hormone. Thus the anterior lobe of the pituitary, which raises the blood sugar, is stimulated when the blood sugar drops, by insulin, oral antidiabetics, etc. But stimulation of the anterior lobe of the pituitary raises the blood pressure, so that when the blood sugar drops, along with the subsequent increase of the blood sugar, a rise in the blood pressure also should occur. Indeed, as was pointed out before, with hyperglycemia a relatively low blood pressure is found, and when the blood sugar level drops, the blood pressure rises. It should be emphasized that such increases in blood pressure occur only with pre-existing hypertension.

In addition to raising both the blood sugar and the blood pressure, the anterior lobe of the pituitary has other effects, such as production of corticosteroids. These are known to lead to cardiovascular changes, and, therefore, stimulation of the anterior lobe of the pituitary brought about by a drop in the blood sugar may lead to augmentation of the hypertension and/or

other cardiovascular changes—perhaps immediate cause of the increased mortality. Hypertension may be but not necessarily is a part of the picture since, as been mentioned, lowering of the blood sugar is followed by increase in the blood pressure in those diabetics only in hypertension pre-exists.

If it is accepted that lowering of blood sugar has harmful rather than beneficial consequences, it is clear that a re-orientation in diabetic therapy is necessary towards some goal other than reduction of hyperglycemia. As to the oral antidiabetics, they are in a need of modification to conform to the new aims and it is possible that if so modified they will replace a place among the drugs of undisputed usefulness.

EUGENE FOLDES, M.D.
New York

The Forensic Psychiatrist

Editor, MEDICAL TRIBUNE:
This is in reply to "The Forensic Psychiatrist," written by Dr. William Woodruff, which appeared in the December 1, 1971, issue of MEDICAL TRIBUNE. Judge Bazelon and many others are well he right in raising considerable doubts as to the validity of using psychiatrists in their present role in courtroom proceedings. But just because of that, it should be forgotten that the psychiatric role in criminal and civil law is not a legal invention or a legal fiction but a legal reality. It is laid down by the judicial process (legislation, judicial decisions and instructions which psychiatrists obey without being able to influence them directly).

A plausible case can and has been made for psychiatric noncompliance with the judicial role assignments by nonparticipation. Yet the decision of what constitutes rational, professional conduct in this matter is not easy; while irrationally appears convincingly simple because it is simplistic, rationality is almost always complex and ambiguous. The refusal of any scrupulous, "good" psychiatrist to accept a compromise in style, language, and attitude imposed upon him professionally by the presumably rational legal rules leaves by negative selection these vitally important matters of social decision making of trials to the professionally less-trained, less-consciousness, and hence often prepotentially punishment-minded psychiatrist or the sensation-seeking juror.

The age-old suggestion that psychiatric opinion should be given weight only at the jury decides on the "facts" whether or not the individual committed a particular act is a deplorable misunderstanding of basic notions. Our current criminal law stipulates that only the commission of a set of undesirable "facts" to be determined by external evidence (defined by code or judicial decisions) with an internal state of mind (intent or otherwise) constitutes a wrongful act or a crime.

The killing of another human being is particular act determinable by "facts" may be self-defense, justifiable homicide, involuntary or voluntary manslaughter, second- or first-degree murder. The fact of the act (if the definition of fact is restricted to elements determined by external evidence) or merely that a human being was killed by a certain person or persons, whether this act constituted a crime, or what degree of crime, can to our present system only be determined by the internal evidence of state of mind. But who is an expert on this state of mind if not psychiatrists and other behavioral scientists? Should the criminologically crucial state of mind question, precisely due to its complexity and difficulty, be left to the whims of arbitrariness, and prejudice, or fact-based without benefit of expert opinion?

That the current criminal law is based on many questionable assumptions and contains strong bias in favor of ineffective punishment is another matter that could and should for purposes of change be incessantly pointed out by court psychiatrists, who, however, have a chance to do so only if and when they participate to the fullest in the judicial process.

FREDRICK J. HACKER, M.D.
Beverly Hills, Calif.

Wednesday, March 1, 1972

Wednesday, March 1, 1972

MEDICAL TRIBUNE

Device Aids Measurement, Treatment Of Nasality in the Most Severe Cases

Medical Tribune Report

BIRMINGHAM, ALA.—A device to help in the measurement and treatment of nasality in patients whose nasality may be so severe that their speech is almost unintelligible has been developed at the University of Alabama's bioacoustic communications laboratory.

The device is called "Tonar," which stands for "the oral-nasal acoustic ratio," said Dr. Samuel Fletcher, director of the laboratory. It is designed to monitor human speech and provide feedback to the patient whenever certain speech patterns improve.

Patients with nasality problems speak into the machine, which lets them know how much nasality they are producing. Dr. Fletcher said. They are asked to repeat sentences representing different sound patterns. Some words and phrases tend to be more nasal than others. Over a period of time, by taking cues from Tonar, the speaker begins to know when he is speaking normally and when he is not.

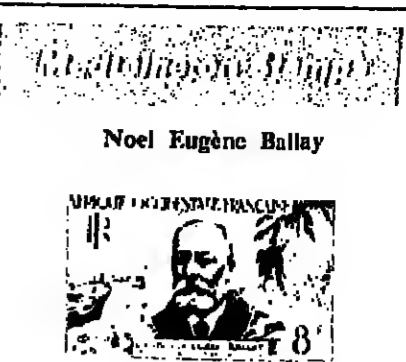
Tonar separates the sounds that come

from nose and mouth and instantly computes the acoustic ratios, he explained.

"The ability to measure nasality makes us able to determine the benefits of treatment," Dr. Fletcher said. "For example, a surgeon can measure whether one procedure improves the ability to speak more than another, or an internist can determine the benefits of a drug used to reduce inappetence from a muscle disease that causes nasality."

The device will prove useful in the treatment of cleft palate patients, the deaf, the mentally retarded, the cerebral palsied, patients with such diseases as multiple sclerosis or myasthenia gravis, and those who through surgery, accident, or disease, have lost use of organs in the mouth, Dr. Fletcher said.

Formerly, the detection and treatment of extreme nasality have depended upon the human ear to evaluate responses and judge improvement, Dr. Fletcher said. The ability to perform this task in a reliable way over a period of time is doubtful for the human ear but "completely reliable" with Tonar is the speech pathologist's tool.



Noel Eugene Ballay

Physician and colonizer, Ballay (1847-1902) was born 125 years ago at Fontenay-sur-Eure, France. He studied at the University of Paris and received his medical degree in 1880.

Entering the French Navy Medical Corps as a surgeon, Ballay participated in the exploration of the Congo's Ogawa River territory. He was also appointed medical adviser and health officer to the Gabon expedition.

Ballay worked to establish the French colonies of the Senegal. He served as the first Governor of French Guinea in 1891, then of Senegal.

French West Africa issued the stamp in 1954.

Text: Dr. Joseph Kler
Stamp: Minkus Publications, Inc., New York

Betadine will help him save face

Surgical Scrub Skin Cleanser

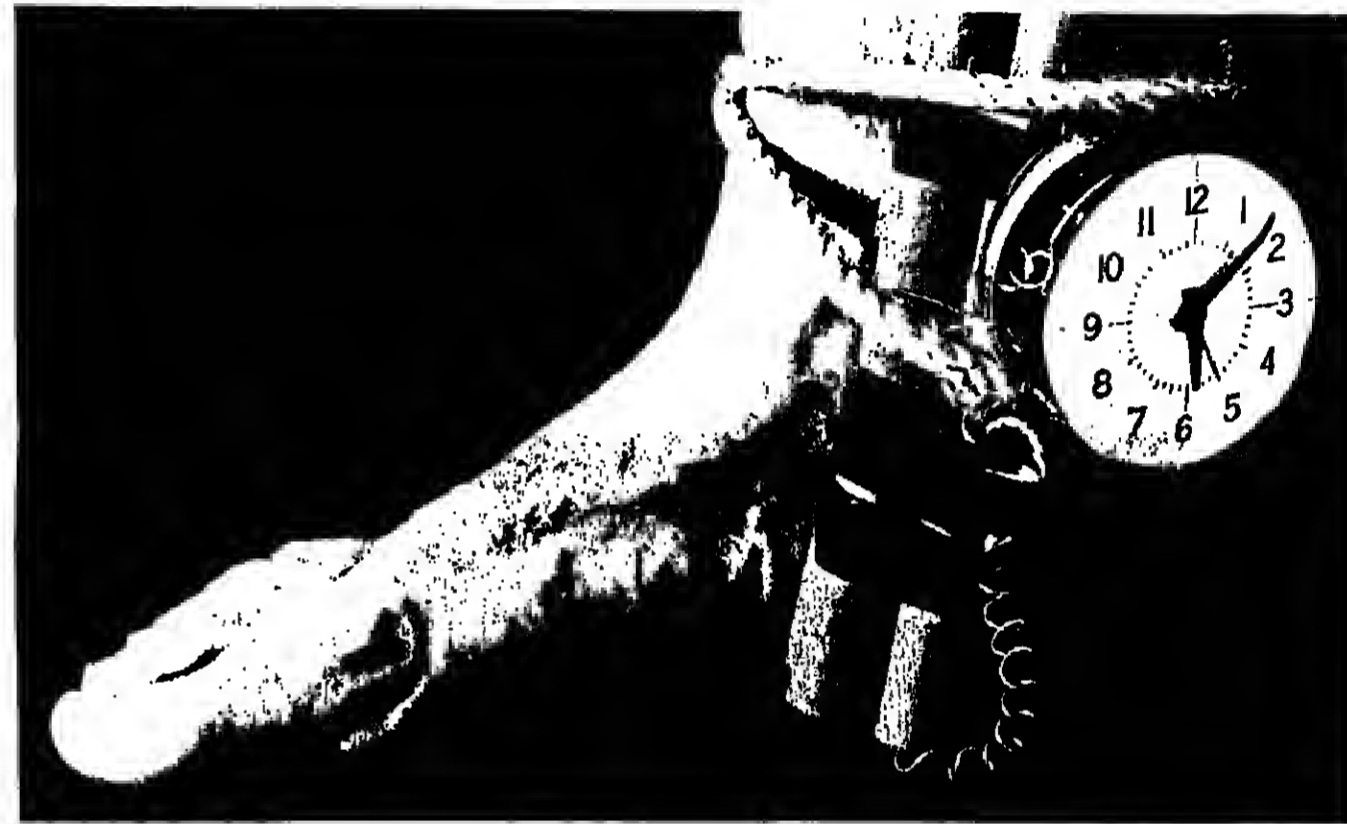
Acting as some of his young life's most embarrassing moments, you can help to alleviate his problem with Betadine Surgical Scrub Skin Cleanser. Its powerful antiseptic action helps prevent the spread of infection in acne lesions.

Betadine Surgical Scrub Skin Cleanser provides the same powerful, topical broad-spectrum microbicidal action that NASA employed in decontamination procedures in the Apollo splashdowns. It contains no hexachlorophene. Unlike some chemical agents that are merely cosmetic and require repeated application, Betadine Surgical Scrub Skin Cleanser is fully effective with a single application.

Betadine Surgical Scrub Skin Cleanser helps prevent the spread of infection in acne lesions.



Purdue Frederick
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rheumatoid arthritic blowups... Tandearil

oxyphenbutazone NF
Geigy

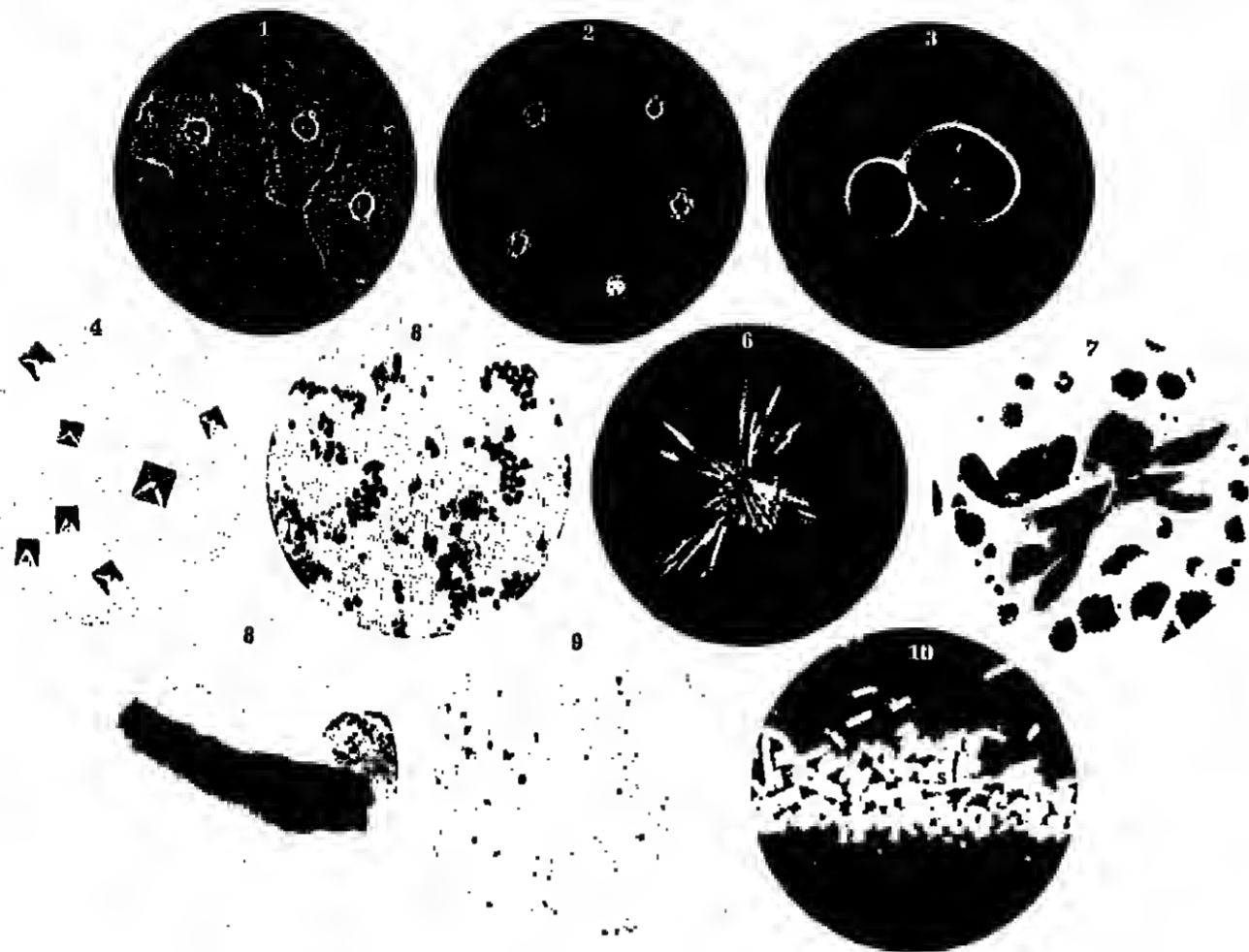
Tablets of 100 mg.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting therapy. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any signs of fever, sore throat, oral lesions (symptoms of blood dyscrasia), dyspnea, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin lesions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Repeat treatment periods to one week in patients over sixty.

Contraindications: Children 14 years or less; ankylosing spondylitis; history of or symptoms of G.I. ulceration or perforation; severe renal impairment; severe liver disease; systemic edema; presence of drug allergy; blood dyscrasias; hepatic or cardiac dysfunction; hypertension; hypothyroidism; systemic edema; ankylosing spondylitis; history of or symptoms of G.I. ulceration or perforation; severe renal impairment; severe liver disease; systemic edema; presence of drug allergy; blood dyscrasias; hepatic or cardiac dysfunction; hypertension; hypothyroidism; systemic edema; ankylosing spondylitis; history of or symptoms of G.I. ulceration or perforation; severe renal impairment; severe liver disease; systemic edema; presence of drug allergy; blood dyscrasias; hepatic or cardiac dysfunction; hypertension; hypothyroidism; systemic edema; ankylosing spondylitis; history of or symptoms of G.I. ulceration or perforation; severe renal impairment; severe liver disease; systemic edema; presence of drug allergy; 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A question of identification

At a recent urology convention,* physicians correctly identified 7 out of 10 of these photomicrographs.



*45th Annual Convention, American Urological Association, North Central Section, Detroit, September 22-25, 1971

- ☐ Calcium oxalate crystals.
- ☐ Squamous epithelial cells.
- ☐ Red blood cell cast.
- ☐ Clusters of white blood (pus) cells.

Score yourself.

Answers appear below.

- ☐ Epithelial cells.
- ☐ *E. coli*, fluorescent stain.

- ☐ *P. mirabilis*, flagella stain.
- ☐ Calcium carbonate crystals.
- ☐ Crystallized red blood cells.
- ☐ Malignant cells.

And when susceptible *E. coli* is identified, start with Gantanol[®] (sulfamethoxazole)

Gentanol (sulfamethoxazole) is dependable, basic therapy for patients with nonobstructed acute, recurrent or chronic urinary tract infections; i.e., pyelonephritis or cystitis.

Effective control of primary bacterial offenders
Susceptible *E. coli*, the most common cause of initial urinary tract infections, can be effectively controlled by Gantanol. Its antibacterial spectrum also includes susceptible urinary pathogens such as *Klebsiella-Aerobacter*, *Staph. aureus*, *Proteus vulgaris* and *Proteus mirabilis*.

Prompt antibacterial blood and urine levels—in from 2 to 3 hours

Therapeutic blood/urine levels are reached rapidly, usually in from 2 to 3 hours after the initial 2-Gm adult dose, then maintained easily with Gantanol Tablets or the pleasant-tasting Gantanol Suspension.

Effective in chronic infections

The elderly and debilitated not uncommonly develop nonobstructed chronic or recurrent pyelonephritis or cystitis—which sometimes is difficult to eradicate. Often these infections, when due to susceptible organisms, can be controlled with Gantanol.

12 hours of therapy with every dose

Either dosage form of Gantanol given b.i.d. yields up to 12 hours of antibacterial activity... the around-the-clock coverage your patients need. Symptomatic improvement often comes 24 to 48 hours after the start of therapy. Gantanol, on proper dosage schedule, is generally well tolerated, with relative freedom from complications. However, the usual precautions during sulfonamide therapy should be observed, including maintenance of adequate fluid intake, frequent c.b.c.'s and urinalyses with microscopic examinations. It should be noted that the increasing frequency of resistant organisms is a limitation of usefulness of antibacterial agents, including sulfonamides, especially in chronic or recurrent u.i.i.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in acute, recurrent or chronic urinary tract infections (primarily pyelonephritis, cystitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, etc., less frequently, *Proteus vulgaris* and in the absence of obstructive uropathy or foreign bodies).
Note: Since in vitro sulfonamide sensitivity tests are not always reliable, carefully correlate in vitro sulfonamide sensitivity tests with bacteriologic and clinical responses. Add aminobenzazole acid to culture media of patients receiving sulfonamides. The increasing frequency of resistant organisms is a limitation of usefulness of antibacterial agents, including sulfonamides, especially in chronic or recurrent urinary tract infections.

Dosage: Sulfonamide hypersensitivity: Infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis). Usual dose is as follows:
Adults—2 Gm (4 tabs or teasp.) Initially, then 1 Gm (2 tabs or teasp.) b.i.d. or t.i.d. depending on severity of infection. **Children—0.5 Gm (1 tab or teasp.)** 1/20 lbs (4 tab teasp.) b.i.d. followed by 0.25 Gm (1/2 tab teasp.) b.i.d. Maximum dose for children should not exceed 75 mg/kg/24 hrs.
Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

Warnings: Safe use in pregnancy has not been established, and teratogenic potential has not been thoroughly investigated. Sulfonamides will not eradicate or prevent sequelae to group A streptococcal infections, i.e., acute rheumatic fever, glomerulonephritis. Deaths from hypoprothrombinemia have been reported. Early clinical signs such as sore throat, fever, pallor, purpura or jaundice may indicate serious blood disorders. Complete blood counts and urinalyses have been reported. Sulfonamide therapy in chronic renal diseases of children under 5 years.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias: agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia; allergic reactions: erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions; periorbital edema, conjunctival and scleral injection; photosensitization; ethiolysis and allergic myocarditis; gastrointestinal reactions: nausea,

anorexia, abdominal pain, hepatitis, ulceration, acute pancreatitis and stomatitis; C.N.S. reactions: headache, peripheral neuritis, menial depression, convulsions, polyneuritis, lumbago, vertigo and insomnia; and ototoxic reactions: drug fever, chills, toxic nephritis with oliguria and anuria, pericarditis nodosa and its phenomenon. Due to certain chemical similarities with some xanthines, diuretics (acetazolamide and thiazide) and oral hypoglycemic agents, sulfonamides have caused rare instances of gastric production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age, except adjunctively with pyrimethamine in congenital toxoplasmosis. Usual dose is as follows:

Adults—2 Gm (4 tabs or teasp.) Initially, then 1 Gm (2 tabs or teasp.) b.i.d. or t.i.d. depending on severity of infection. **Children—0.5 Gm (1 tab or teasp.)** 1/20 lbs (4 tab teasp.) b.i.d. followed by 0.25 Gm (1/2 tab teasp.) b.i.d. Maximum dose for children should not exceed 75 mg/kg/24 hrs.
Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

Answers: 4. Calcium oxalate crystals. 5. Squamous epithelial cells. 6. Red blood cell cast. 7. Clusters of white blood (pus) cells. 8. *E. coli*, fluorescent stain. 9. *P. mirabilis*, flagella stain. 10. Crystallized red blood cells. 11. Malignant cells.

In nonobstructed urinary tract infections due to susceptible organisms

Gantanol[®] B.I.D.
(sulfamethoxazole)
Tablets/Suspension
Basic therapy

Roche Laboratories
Division of Hoffmann-La Roche Inc.
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Somatic Surfeit Syndrome

FOR MANY YEARS a steady stream of persons, young and middle-aged, have found their way to Duke University and to spas, there to do dietary penance over some months for bodily excesses, which have accumulated over some years. The visible abnormality is obesity, usually of gross degree, but there is an accompanying constellation of clinical or subclinical disorders. These include hypertension, hyperglycemia, hyperlipidemia, hyperuricemia, and frequently high hemoglobin, high hematocrit, and hyperbilirubinemia. In the young—and the syndrome begins in youth—it is uncontrolled obesity that brings patients to such regimen-oriented retreats; in older persons the motivation for treatment may be due also to such accompanying complications as diabetes, gout, and cardiovascular disease.

The important, and gratifying, point about this metabolic syndrome is that most if not all of the abnormalities are reversible with drastic weight loss over the many months needed to accomplish this. Patients who have worked long and hard to achieve such improvement are more often than not strongly motivated to maintain their lowered weight, much more so than the usual overweight person, who may diet, however stringently, for brief periods for cosmetic purposes and then lapse. For persons with this metabolic syndrome weight loss is not merely a cosmetic but a vital matter, and the earlier the better, for if it is neglected until middle life complications rather than the primary disorder will have to be dealt with.

The nature of this syndrome of somatic surfeit is obscure, but there may be a common anabolic denominator. Insulin has potent anabolic effects, lipogenic in particular, as does growth hormone, and their effects are greatly augmented by glucose, with rapid RNA and protein synthesis. In tissue studies, H.M. Goodman, of Harvard Medical School, has found, for example, "that all of the early effects of growth hormone could be duplicated in the absence of the hormone simply by raising the concentration of glucose in the medium threefold" (Ann. N.Y. Acad. Sci. Monograph on Growth Hormone, 148:419, 1968).

It is a long way from experimental studies of isolated rat tissues to the clinical scene, but several epidemiologic nutritional studies seem notably relevant. Almost without exception, primitive groups consume little pure sugar although the intake of the more slowly assimilated complex carbohydrates may be high. These produce less precipitous peaks of blood glucose than do refined sugars. As primitive peoples become Westernized in their dietary habits, refined sugar intake rises strikingly. With this comes an increase in stature of the young generation and increase in obesity, diabetes, cardiovascular disease, and the many ills characterizing Western civilization.

Recently Otto Schaefer presented interesting data concerning the nutritional patterns of several Canadian Eskimo communities and the profound changes that occurred as they adopted the white man's civilization in the decade between the mid-1950s and mid-'60s (Nutrition Today 6:8 Nov.-Dec., 1971). Most striking was a quadrupling of refined sugar consumption—i.e., sucrose—in this period; and it is in this dietary modification specifically that Dr. Schaefer ascribes the many changes in physique and health that have taken place. Among them are increased stature, earlier puberty, and increased skinfold thickness and obesity. Evidently anabolic factors have been at work, triggered not by better protein nutrition, for, indeed, protein intake has decreased, but by sugar as a stimulus to insulin production and, presumably, growth hormone. With this there have been conspicuous changes in health, as diseases of civilization previously rare among the Eskimos have become strikingly prevalent. These include a more than fivefold increase in atherosclerotic disease, a threefold rise in diabetes, increase in serum cholesterol and other blood lipids, cholelithiasis, dental caries, and acne vulgaris. Evidently acculturation to the dietary patterns of Western civilization is something less than a blessing. The culprit in this diabolic anabolism appears to be sugar, which wreaks havoc with all of us and most clearly in those with the somatic surfeit syndrome. R.S.G.

And Now Saccharin

SACCHARIN has been removed from the list of food additives "generally recognized as safe" because of the reported finding of bladder tumors in rats fed huge daily quantities to their diet. If by microscopic study the tumors are judged malignant, the Delaney amendment will require the FDA to ban saccharin outright in all foods. That 14-year-old amendment compels the FDA to interdict any food additive shown to cause cancer in animals, or to man, upon ingestion—in whatever

amounts. Two years ago, when cyclamate was outlawed, MEDICAL TRIBUNE pointed to the fact that the evidence against cyclamate implicated saccharin as well. "We are not suggesting," we added, "that saccharin be banned. We question the wisdom of banning cyclamate and suggest that when medical questions are handled as political questions, they are likely to be mishandled." Perhaps the Delaney amendment should be reconsidered.

The Psychiatrist Who Came to Dinner

CLINICAL QUOTE: "I actually move in with some patients for periods ranging up to three days. This home-living, which I began about a year ago, is valuable both as a research tool and as a method of treatment. It has enabled me to

learn a great deal about the lives of patients and to help them work out some of their problems." (Dr. Alfred A. Messer, research psychiatrist, Northside Community Health Center, Atlanta, Ga.; see page 1.)



"I wonder what it means when Dr. Sigmund Freud himself appears in your dreams."

Drug Equivalence

Editor, MEDICAL TRIBUNE:

Articles in recent issues of MEDICAL TRIBUNE have publicized the finding of marked variability in potency of different brands of digoxin and have commented on the striking silence of the FDA in this matter. This silence is in contrast to the raucous behavior of the FDA in the cyclamate and other, so-called consumer-oriented matters. Your articles indicate that drug recalls of various digoxin products have been numerous for several years, but, as you also indicate, I have yet to receive notice from the FDA that a potentially critical situation such as this existed.

May I suggest a possible explanation? If one simply recalls Sen. Gaylord Nelson's derisive and contemptuous comments at the drug hearings of a few years ago when the question of possible generic inequivalence was respectfully raised, it can readily be seen that this subject of drug equivalence is a sensitive issue, packed with political (and demagogic) overtones ever since the days of the late Senator Kefauver. Thus, to suggest that all digoxins are not the same, and that a broad-name product (Lanoxin) might well serve as a standard, would be political less majestic, and not likely to amuse pressure groups. In and out of government, who for so long have insisted that generic equivalence "to lower the cost of medicine" must become a fact of life for physicians.

If generics were the order of the day, I believe those so loud in their praise of cheap drugs for all would whisper to the pharmacist when having their prescription filled, "Make mine Lanoxin." MEDICAL TRIBUNE deserves great credit for these articles that raise such important questions of integrity.

L. P. BRADY, M.D.
Hampton, Va.

Health Insurance

Editor, MEDICAL TRIBUNE:

I agree with Dr. John Knowles (MEDICAL TRIBUNE, January 19) that ideally all Americans should have health insurance. However, to finance such coverage by employers and employees inevitably results in increased costs of production with subsequent disadvantage for American goods in international commerce.

I also agree that the coverage should be comprehensive to cover all available services for all known conditions affecting directly people's health. But to state that health insurance should cover 100 per cent of the cost for the medically indigent I believe is going too far because any time you cover 100 per cent of the costs of anything for anybody you're going to get overutilization and abuse of the com-

modity, facility, or service that you are providing.

Dr. Knowles said such insurance should remove all economic barriers to obtain needed care. As a practicing physician in a busy rural family practice I can state that this would result in chaos in my office. At the present time we are being inundated by a wave of sick humanity (30 to 40 per cent of whom, according to Dr. Knowles, complain that our fees are too high).

If all economic barriers to needed care were removed it would be physically impossible to care for the sick in my office.

I disagree with Dr. Knowles that deductibles and coinsurance are wrong even for the "poor." I do however believe that there should be a gradation of deductible and coinsurance according to the ability to pay and will concede that the destitute transient without any visible means of support should be cared for gratis. I believe the overwhelming majority of physicians in actual care of sick patients on a daily basis agree with this.

C. J. IANNINO, M.D.
Fairfield, Ill.

A.M.A. Defended

Editor, MEDICAL TRIBUNE:

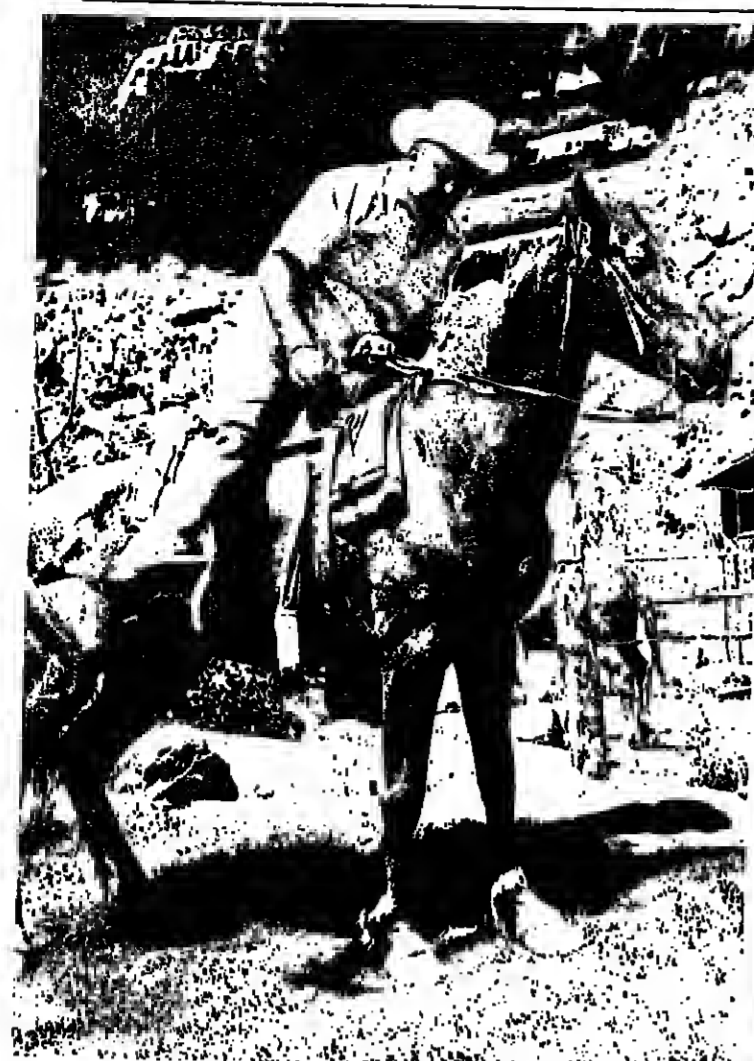
In your December 22, 1971, issue a physician who is strongly against abortion criticizes the A.M.A. and its delegates for their liberal attitude towards abortion. I disagree entirely with him that organized medicine does not represent the majority of the physicians on this particular issue—abortion.

The opposition to abortion is for the most part based on a religious dogma. However, there is not a word in the Bible, to my knowledge, that maintains that the fetus is a human being. The preponderance of scientific evidence is that the fetus does not have a consciousness and therefore is not a human being.

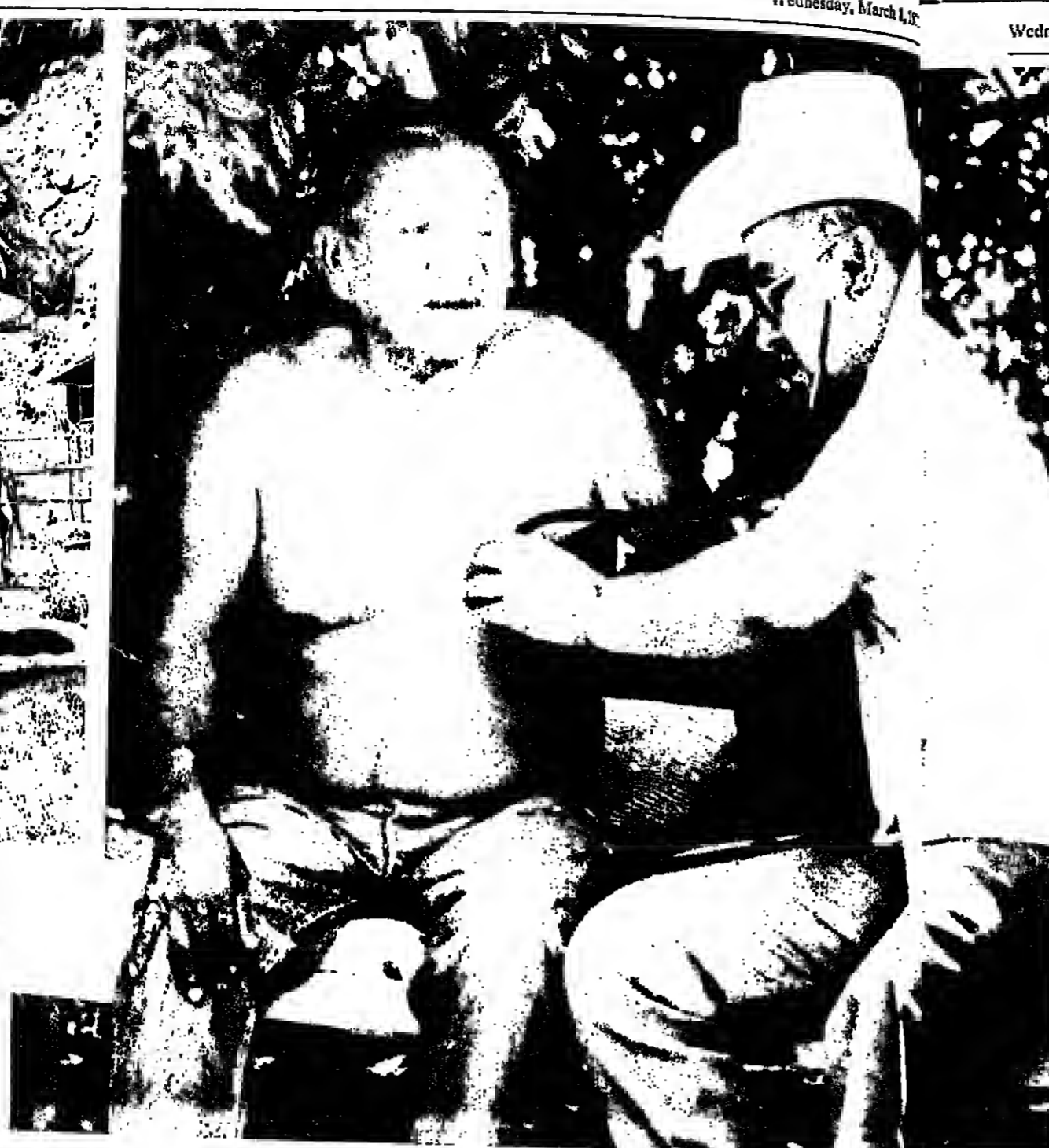
Albrecht Peiper, M.D., states that "the acts of the newborn normal infant can be handled by his brain stem because these acts can be observed in a newborn anencephalic monster, who has no cerebral hemisphere and no cortex." He also said that "some of the reactions of the human infant are to be observed also in the young chimpanzee, with his simple brain. Hiccup and yawn can be seen in the newborn of a lowly rabbit." Dr. Frederick Gibbs states that "a newborn infant—has about as much of an EEG as has a wet sponge."

Further, it is a woman's own body, and since she must answer to her own God, she should have every right to terminate an unwanted pregnancy. I go along with Thomas Jefferson, who states, "Conduct of government extends only to things injurious to others."

PETER VAN ZANTE, M.D.
Pella, Iowa



Community Health Medic John Gobert goes on house calls on horseback. Right, Gobert, an ex-medical corpsman, checks patient outside home of the Havasupai Reservation, situated on the floor of the Grand Canyon. Indians, Eskimos, and Aleuts are faced with widespread nutritional deficiencies, as well as otitis media, and mental and environmental health problems.

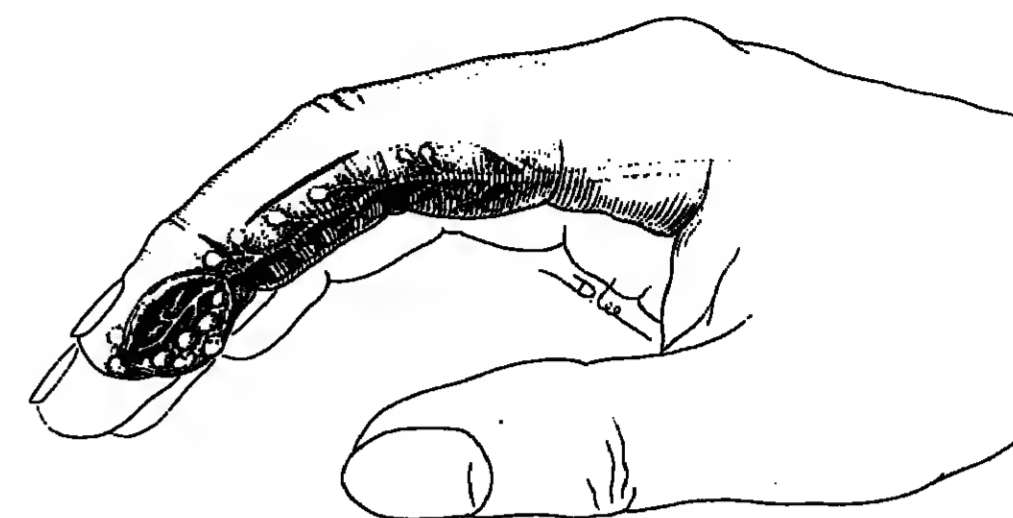


Hyperplastic Pacinian Corpuscles Seen in 66-Year-Old

A CASE of hyperplastic pacinian corpuscles causing extreme digital pain in a 66-year-old woman who had previously sustained a whiplash injury with slight trauma to the right shoulder has been reported by Drs. W. R. Hart, N. W. Thompson, D. H. Hildreth, and M. R. Abell, at the University of Michigan Medical Center.

Slightest touch produced excruciating pain in the right index finger, preventing patient from doing everyday tasks. Exploration of volar aspect of the finger tip and exposure of the pulp space showed rice-sized glistening nodules extending from the periosteum to the skin and attached to fine branches of the digital nerves. Excision of these resulted in partial alleviation of pain and proximal bilateral digital neurectomy was eventually performed (see right, below).

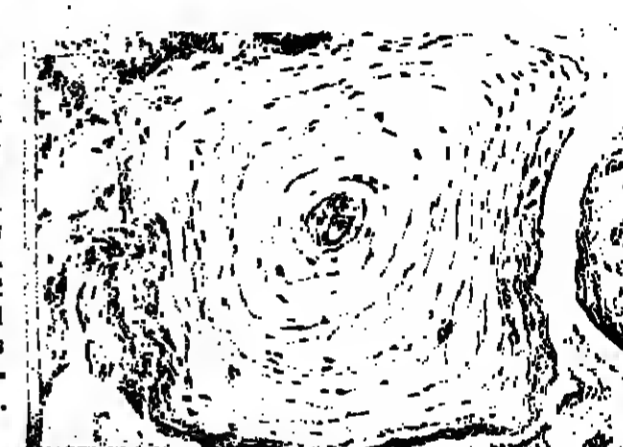
The digital pain probably resulted from a post-traumatic proliferation of pacinian corpuscles that impinged on the digital nerves because of the closed space of the finger, the physicians said.



Shaded area of drawing indicates locales of pain sensation. Also illustrated are distribution of hyperplastic pacinian corpuscles and sites of surgical incisions. Enlarged pacinian nodules were found attached along length of nerve by filamentous nerve fibers. All of the corpuscles were excised.



Subcutaneous adipose tissue specimen, removed during proximal bilateral neurectomy through longitudinal incisions, contained cluster of large mature pacinian corpuscles and bundles of peripheral nerves, left. Each corpuscle, right, consisted of central nerve fiber surrounded by numerous concentric lamellae enclosed within thin collagenous capsule. A segment (2 cm.) of each digital nerve and all corpuscles were excised. There was no recurrence of the patient's symptoms one year after the operation.



American Indians Trained to Bring Health Care to Their Own People

SEEKING TO BRIDGE GAPS—both cultural and geographic—in conveying health care, the Indian Health Services' Phoenix Indian Medical Center has inaugurated a physician's assistant training program to produce Community Health Medics (CHMs). Ten American Indians, all with prior medical background, have just finished the first year of classroom and field training and will now complete one year of preceptorship under a senior physician.

As part of the community where they work, CHMs function as a focal point for local health programs such as immunization projects, maternal and child health clinics, and well-baby clinics. CHMs are equipped to obtain patient histories and to perform routine physical exams and clinical lab tests.



Resident pediatrician Elaine M. Sayre (l.) makes rounds with CHM John Williams at the Phoenix Indian Medical Center, above. Rosemary Fitch, R.N., CHM Arlie Beeson, and Dr. LaLitha Bai, Bangalore, India, examine child. Dr. Bai is on assignment at the center under the Exchange Visitors' Program. One-fifth of Amerindian deaths occur among babies who are less than one year old. The majority of infant deaths are due to respiratory and gastrointestinal tract diseases.

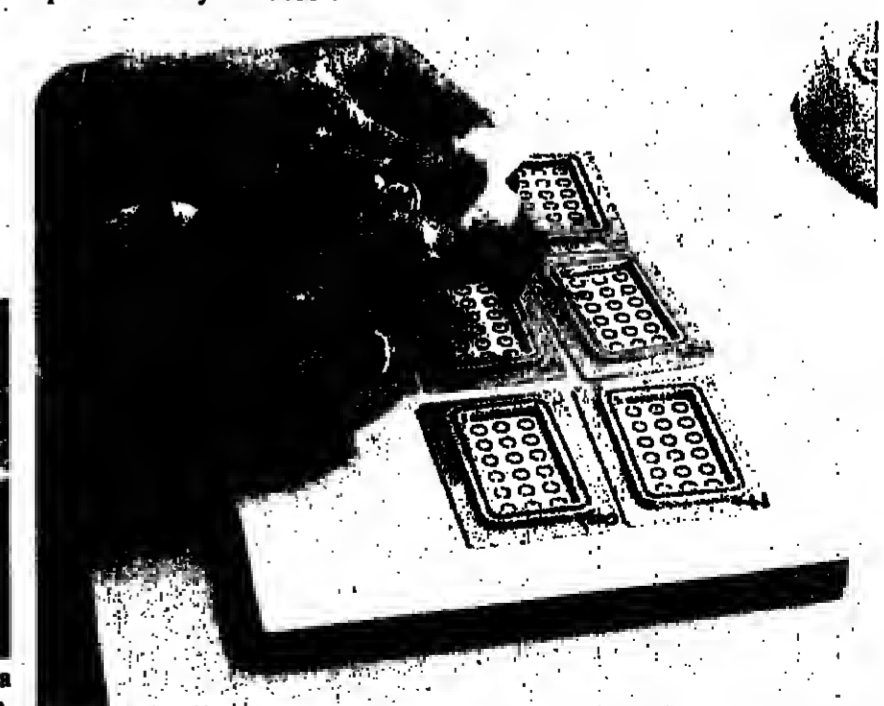


being maintained by machine at round-the-clock land-and-air transportation system. The facility is complete with typing units in five countries and 200 hospitals.



Donor organs are brought to necessary centers by a round-the-clock land-and-air transportation system. Above, a blood donor. Creation of a "Eurodonor" has been suggested by Dr. van Rood, director, immunohematology department of University Hospital.

Share alike: A proposal for an international organ exchange program, by Dr. Johannes van Rood, of University Hospital, Leiden, the Netherlands, has, in two years, evolved into a network covering centers in Belgium, France, Italy, and other countries. Named Eurotransplant, it has stimulated advances in many areas of kidney research, such as immunosuppression, bone marrow transplants, and the HL-A system. The project has established a computerized central registration of dialysis patients with immunologic data and degree of urgency and compiled a listing of 3,000 donors. Officials immediately initiate a matching program for a suitable recipient upon availability of a donor.



Cell and blood typing and other tests are also on a 24-hour schedule. About half the typings are carried out between midnight and 6 a.m. Blood from Copenhagen, Oslo, Geneva, and Vienna, for example, was utilized in one recent case.



If the patient is overanxious one to two hours prior to surgery, the anxiety



Additionally, Injectable Valium (diazepam) can

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; tetanus; status epilepticus and severe recurrent seizures; anxiety

prior to gastroscopy, esophagoscopy, and surgical procedures; cardioversion (I.V.).

Contraindicated: In infants; in patients with known hypersensitivity to the drug; in acute narrow angle glaucoma; may be used in patients with open angle glaucoma receiving appropriate therapy.

Warnings: Inject I.V. slowly, directly into vein; take at least one minute for each 5 mg (1 ml) given. Do not mix or dilute with other solutions or drugs. Do not add to I.V. fluids. Rare reports of apnea or cardiac arrest noted, usually following I.V. administration, especially in elderly or very ill and those with limited pulmonary reserve; duration is brief; resuscitative facilities should be

available. Not recommended as sole treatment for psychotic or severely depressed patients. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs. Caution against hazardous occupations requiring complete mental alertness. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy,



can be relieved with 10 mg of Injectable Valium (diazepam) I.M.



Injectable Valium (diazepam) is a useful premedicant for reducing undue anxiety. Recall of preoperative procedures is markedly diminished. When given in conjunction with narcotics, a reduction of narcotic dosage should be considered. (See summary of prescribing information.) Injectable Valium should not be mixed with other drugs, solutions, or fluids. The new 10-mg disposable syringe can help you observe this precaution at the same time it helps assure aseptic handling. Injectable Valium seldom significantly alters vital signs. Nevertheless, there have been infrequent reports of hypotension and rare reports of apnea and cardiac arrest, usually following I.V. administration. Resuscitative facilities should be available.

To relieve excessive preoperative anxiety, remember Injectable Valium (5 mg/ml)—2-ml ampuls, 10-ml vials, and the new 2-ml Tel-E-Ject™ (disposable syringes).

diminish recall of the preoperative procedure.

lactation or women of childbearing age, weigh potential benefit against possible hazard to mother and child.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium, such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Not recommended for bronchoscopy, laryngoscopy, obstetrical use, or in diagnostic procedures other than

gastroscopy and esophagoscopy. Laryngospasm and increased cough reflex are possible during gastroscopy; necessary countermeasures should be available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Since effect with narcotics may be additive, appropriate reduction in narcotic dosage is possible. Use lower doses (2 to 5 mg) for elderly and debilitated. Safety and efficacy in children under 12 not established.

Side Effects: Drowsiness, fatigue, ataxia, confusion, depression, constipation, dysarthria, diplopia, headaches, hypoactivity, hiccups, hypotension, incontinence, jaundice, nausea, changes

in libido, changes in salivation, phlebitis at injection site, urinary retention, skin rash, syncope, slurred speech, urticaria, tremor, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbance and stimulation have been reported; should these occur, use of the drug should be discontinued. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy. Minor EEG changes, usually low-voltage fast activity, of no known significance.

ROCHE Roche Laboratories Division of Hoffmann-La Roche Inc. Nutley, N.J. 07110

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benefits every step of the way.

Psychiatrist Reports Success With House Calls and Visits

Continued from page 1

physical symptoms. But if a patient's primary complaint is unbearable anxiety or depression, you have to study the total life situation of that person—and there's no better place to do this than his home."

Dr. Messer thinks it is important for a psychiatrist to get to know all members of his patient's family.

"The scientific hypothesis under which I operate," he said, "is that no member of a family gets sick alone—and no member gets well alone."

Treated Families Three Years

Dr. Messer treated families at the Georgia Mental Health Institute for about three years. "We admitted entire families to the hospital, and while they were there we observed their behavior and interaction. My decision to do home-living resulted from my awareness that we needed more information about a family's life at home."

One reason that he favors home visits is that many people avoid visiting a doctor's office. "When patients come to see us," he said, "they come into our territory. They use our furniture, our ashtrays, our rooms, and they are automatically in a one-down position—similar to that of a child with an adult. This one-down position may be onerous or humiliating to them."

"When I go into the home of a patient, he has a better chance of having equal status with me. My position is something like that of the old country doctor. Not only did he know you as a patient, but he knew everyone in your family and all the circumstances of your life."

During an office visit, Dr. Messer said, a psychiatrist can see the "interaction" of people only for a short period.

"Unless you go into a patient's home," he stressed, "you never see some of the other important elements—such as the kind of neighborhood they live in, the time they go to bed and get up, their social and economic situation, their patterns of friendship, and what goes on at mealtimes, which is a very important time for any family."

While visiting a home, Dr. Messer routinely inspects the house from attic to cellar. He looks into the refrigerator and closets and sees the location of such things as beds, TV sets, and telephones.

Dr. Messer said he has patients in Michigan and Colorado with whom he spends three days twice a year "to help them work out some of their problems." He has a patient in Florida whose home he visits for one day about every six months. In Atlanta he may visit a patient's home one afternoon each week.

"One of my problems is to get the family not to treat me as a guest," he related. "I tell the family that I'm in the home as a helping person. At times, I am part of the family, and at other times, I exercise a therapeutic role. During the course of a day in a patient's home, I conduct individual or family therapeutic sessions. At the end of my stay, I try to have a general session with the entire family in which we review significant problems and ways of solving them."

"At the moment, the families I treat are those who can afford the equivalent of a private fee. This fee may add up to several hundred dollars a day. Eventually, I hope that I can do home-living with less affluent patients."

Time Consumption Great

Dr. Messer said the main reason that home-visiting by psychiatrists is very rare is that the time consumption is great.

"Second," he said, "we are not geared or trained for observing family interaction. We need to know more sociology and cultural anthropology—particularly if we are studying or treating members of minority groups."

"Third, patients have not demanded that we visit them. No one particularly likes the idea of having a stranger in the home. But after patients recognize the value of such visits, the welcome mat is out."

Dr. Messer said that other psychiatrists have shown great interest in his home-living "because they recognize the validity of this kind of approach."

Two-Nation Program Planned



Soviet Ambassador Dobrynin (center) banters with Mr. Richardson (left) and Dr. Egeberg during news conference on health subcommittee that will be organized through an agreement between the U.S. and U.S.S.R. Areas are environmental health, cancer, and heart disease. Mr. Dobrynin said heart disease and cancer are big killers in both nations.

U.S., Soviet Agree to Pool Research in 3 Health Areas

Medical Tribune Report

WASHINGTON—A joint agreement to pool research in cancer, heart disease, and environmental health questions was announced here by the United States and the Soviet Union.

The agreement, disclosed at a press conference by Elliot L. Richardson, Secretary of Health, Education, and Welfare, and Ambassador Anatoly F. Dobrynin, provides for the establishment of a Soviet-American Committee for Health Cooperation.

Subcommittees in the three study areas will be set up.

The committee will "identify areas where interests converge," Secretary Richardson said, and then will assign research to avoid duplication. Moreover, he said, joint research teams may be established,

though at first both countries will work with its own scientists.

Cancer, heart disease, and environmental health were chosen because they are the most serious problems in both countries, Ambassador Dobrynin said.

Chairmen of the joint committee will be Dr. Roger O. Egeberg, special consultant to President Nixon on health affairs, and Dr. Dmitri Benediktov, a Deputy Soviet Health Minister.

Soviet investigators "are ahead of us in many areas and we hope to learn from them," Dr. Egeberg said, specifically noting the "very thorough, broad, and extremely promising" studies they have carried out on the health of the U.S.S.R.'s entire population.

He said they also had done outstanding work on hypertension, the study of viruses as a possible cause of cancer, and immunology and blood diseases.

Other American members of the committee will be Dr. S. Paul Ehrlich, director of the Office of International Health; Dr. Theodore Cooper, director of the National Heart and Lung Institute; and Dr. David P. Rall, director of the National Institute of Environmental Health Sciences.

The other Soviet members were not identified.

Reported Members Listed

However, they were reported to include the director of the A. L. Myesnikov Institute of Cardiology; the director of the Institute of Experimental and Clinical Oncology; and the director of the A. N. Sytin Institute of General and Communal Hygiene.

Dr. Egeberg first suggested the agreement to Dr. Boris V. Petrovsky, Soviet Minister of Health, in Moscow in 1970. Secretary Richardson said. It was discussed further last May with Soviet officials in Geneva by Dr. Jesse L. Steinfeld, U.S. Surgeon General.

The agreement is similar to that between the National Aeronautics and Space Administration and the Soviet Academy of Sciences on the exchange of information on space research and on measures to permit Soviet and U.S. spacecraft to dock with each other.

Asked if the U.S. is thinking about a similar health research agreement with China, Mr. Richardson said that was farthest.

Mr. Dobrynin pointed out that in both the United States and the Soviet Union, heart disease is the leading cause of death and cancer the second.

Asked if the Soviet Union has pollution of the environment, Mr. Dobrynin said it does, but that it is lagging behind the United States.

Wednesday, March 1, 1972

Tires and Automotive Safety

By SEN. GAYLORD NELSON

Senator Nelson (D-Wis.) has been active in tire safety legislation since 1964. He is the author of the Tire Safety Act of 1966, the Tire Recall Amendment, and the Uniform Tire Quality Grading System, all part of Title II, National Traffic and Motor Vehicle Safety Act (PL 89-564).

DESPITE LEGISLATION and implementation of tire safety laws over the past five years, the American public still lacks confidence in its passenger car tires. This is evident from the large number of letters my office receives (an average of 15 a week) complaining about tire problems.

The National Safety Council says that 7 per cent of all highway fatalities are caused by tire failure. A combination of factors certainly is to blame: poor-quality products, bad manufacturing practices, misuse of tires by consumers (overloading, improper pressure, poor maintenance), higher speed of autos, and bad road conditions.

Although these tire problems are still with us, new laws and regulations should lead to a vast improvement over the previous situation. They include the Federal Motor Vehicle Safety Standard No. 109, effective January 1, 1968, which sets minimum safety performance standards for passenger car tires, as well as a regulation requiring record-keeping so that defective tires can be recalled.

Retreaded tires will have to meet the same standards as new tires. (These standards, however, have been delayed by a court suit brought by a retreaders association.) Another standard sets a six-year limit on tires that can be retreaded.

At the very heart of the tire safety program is the Uniform Tire Quality Grading System for consumer information on passenger car tires, which the Department of Transportation proposed September 17. It will enable the consumer for the first time to evaluate and select tires to meet his safety and budget needs without having to rely on such meaningless descriptions as "super premium" or "cat paws."

Currently tire buyers are confronted with up to 1,100 tire lines produced by 19 manufacturers in the U.S. Most tires come in 12 to 15 different sizes. There are 71 manufacturers world-wide.

Failure rates and recalls. Federal tests in the past three and a half years have influenced the recall of more than 300,000 passenger car tires. In addition, since the establishment of Standard No. 109, nearly 1,000,000 tires have been recalled voluntarily by tire manufacturers.

The extent of these recalls indicates that all is not well with tires. The National Bureau of Standards' "Tire Use Survey: Physical Condition, Use, and Performance of Passenger Tires in the United States of America" states: "We calculate that one new tire out of every four experiences some form of disablement prior to wearout."

Another study cited in the NBS report shows that, of 11,385 drivers interviewed in 1968, 1,462 (about 13 per cent) responded "Yes" to the question: "Any defects in newly purchased tires in the last two years?"

The Department of Transportation's Standard No. 109 tests show the following failure rates: 1968, 6.1 per cent; 1969, 4.1 per cent; 1970, 8.3 per cent; 1971, 6.7 per cent.

Educating the consumer. Until the tire quality grading standards are a reality, the

New Application Deadline For Heart Study Support

NEW YORK—The American Heart Association has advanced the deadline dates by which investigators must submit applications for research support.

The following are new deadlines for support of studies to be conducted during the fiscal year starting July 1, 1973:

Established Investigators and British-American Research Fellows—July 1 deadline instead of September 15.

Grants-in-Aid—applications must be received by October 1 instead of November 1 as in past years.

Additional information on research support and forms to apply for funds may be obtained from the Research Department, American Heart Association, 44 East 23rd St., New York, N.Y., 10010.



SEN. GAYLORD NELSON

One worker in a large tire plant wrote to my office that the assembly line worker is paid on a piece basis—by the number of tires he turns out in a shift. Thus, the worker is discouraged from stopping his machinery or attention to inferior materials or problems with the construction of tires because this cuts down his production and his usefulness to the manufacturer.

Lack of competitive quality controls. It is a fact that there is little real competition for significantly different products within

the tire industry. Each manufacturer is turning out essentially the same product, much as gasoline companies market the same product. Obviously, this lack of real competition fosters a lack of quality controls in the manufacturing process.

What differences exist between different makes of tires are often poorly understood by the public. Hence the competition lies primarily in how the tires are sold in the sales pitch.

It is hoped that the new quality standards, if implemented wisely, will spell out differences in tire quality.

Warranties and rebates. When tires fail, the consumer faces two problems. If his tires are on a newly purchased car, he may be bucked from the auto dealer to the tire manufacturer and back, without receiving adequate adjustment. Or, he may receive inequitable adjustment for tires that are defective or fail prematurely.

In most cases, tires on new cars are not covered by the auto manufacturer's warranty. The auto manufacturer, which sets the specifications and requirements for the tires it buys, should take the responsibility for the new car tire warranty. The FTC has the jurisdiction to move in this area and should be urged to do so.

The large volume of consumer complaints in the auto and tire area has forced the FTC to consider revising its 1960 guidelines for tire and auto advertising.

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Esidrix® (hydrochlorothiazide) Indications: Edema and hypertension. Contraindications: Anuria, diastolic blood pressure below 90 mm Hg, renal shutdown, or any reason. Progressive hepatic disease may accelerate development of hepatic coma. Do not give to patients with known allergy to thiazides or other sulfonamide-derived drugs.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Warnings: Small bowel elements, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. These bowel lesions have caused obstruction, hemorrhage, and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts. Therefore, coated potassium-containing formulations should be used only when dietary supplementation is not practical and discontinue immediately if abdominal pain, distention, nausea, vomiting, or GI bleeding occurs.

Lowering of blood pressure in hypertensive patients may sometimes result in nitrogen retention, and also result in reduced renal blood flow, particularly in those with impaired renal function. If progressive renal insufficiency is observed, discontinuance of drug may be desirable.

Precautions: Perform serum potassium, BUN, uric acid, and blood sugar tests prior to and at appropriate intervals during therapy. Watch patients for clinical signs of fluid or electrolyte imbalance (hypopotassemia, hypochlorasemia, hypokalemia). Warning signs: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, GI disturbances. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively, receiving parenteral fluids, or receiving ACTH during brisk diuresis, in presence of severe cirrhosis.

Interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Oliguria may be exacerbated by concurrent use of diuretics, especially with reference to myocardial activity. (Signs of digitalis intoxication may be produced by hypokalemia.)

Pay special attention to electrolyte balance of patients with severe hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma (confusion, drowsiness, tremor) and test for increased arterial ammonia concentration, sodium and potassium excretion, with hepatic or renal disease, a low salt diet is generally reversed by a uricosuric agent.

Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine. If possible, withhold therapy 2 weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

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therapy. Hypertremia (or frank gout) may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes may become manifest during thiazide therapy. If nitrogen retention indicates onset of renal impairment, discontinue drug.

Adverse Reactions: Gastrointestinal—nausea, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (mitochondrial cholestasis), pericarditis, hypoglycemia, glycosuria. Central Nervous System—dizziness, vertigo, parosmia, headache, xanthopsia. Dermatologic—Hypersensitivity—purpura, photosensitivity, rash, urticaria, necrotizing angitis. Hematologic—leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia. Cardiovascular—orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Miscellaneous—muscle spasms, weakness, restlessness. Whenever adverse reactions are moderate or severe, reduce dosage or withhold therapy. Dosage: Tablets should be taken with or immediately after meals.

Edema: Initial—50 to 100 mg once or twice daily for several days. Maintenance—25 to 100 mg daily or intermittently. Refractory patients may require up to 150 mg daily.

Hypertension: Initial—Usual dose 75 mg daily. Maintenance—After a week dosage may be adjusted downward to as little as 25 mg or upward to as much as 100 mg daily. In resistant patients, up to 100 mg daily may be required. Combined therapy—When necessary, other antihypertensive agents may be added gradually and with caution because of the potentiating effect of this drug.

Dosages of ganglionic blockers should be halved. Supply: Tablets, 50 mg (yellow, scored) and 25 mg (pink, scored). Bottles of 100, 1000, and 5000.

Consult complete literature before prescribing. CIBA Pharmaceutical Company, Division of CIBA-GEIGY Corporation, Summit, New Jersey 07901.

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C I B A

Study Links Myasthenia Gravis With Immunologic Causes

Continued from page 1

lymphocytes from eight MG patients (four with thymic hyperplasia and four with thymoma), one patient with a thymoma but no MG, and six control subjects. The muscle tissue against which the lymphocytes were tested came from cultures of human fetal muscle cells.

One of the phenomena they were looking for was cytotoxicity for muscle cells after the lymphocytes had been stimulated by the mitogen phytohemagglutinin (PHA), which transforms a lymphocyte into a state of offensive readiness. Transformed lymphocytes from MG patients were all cytotoxic for muscle, but none from normals were, nor were the lymphocytes from the one patient with thymoma and no MG.

In addition, the muscle preparation was able to inhibit migration of MG lympho-

cytes—another mark of lymphocyte sensitization, because it helps prevent their leaving the target tissue. And the MG lymphocytes showed a higher rate of transformation with PHA than normal lymphocytes did, which would seem to indicate an enhanced potential for response to an antigen.

All told, said the authors, the tests suggest that thymic lymphocytes in MG are functionally abnormal and are sensitized to muscle antigens.

If such were the case, said Dr. Armstrong, it is still far from clear how a lymphocytic attack on muscle would cause the precise pathology seen in MG. The disease is regarded as an aberration of transmission between nerve and muscle, a derangement of the acetylcholine mechanism. On this classic understanding, a common medical management includes the

administration of an anticholinesterase to minimize enzymatic wipe-out of neuromuscular transmission.

However, the thymus also has long been implicated in MG because it is so often found hyperplastic or with actual tumor. Coauthors of the report here included Richard Nowack, a medical student, Judy Felk, and Drs. Rudy E. Falk and F. G. Pearson.

Ethosuximide Undermedication Blamed in Epilepsy Attacks

From McGill University

Undermedication with ethosuximide for the "absence attacks" of petit mal epilepsy, particularly in children, is suspected by a McGill University investigator after measuring drug levels in plasma.

Dr. Allan L. Sherwin used gas chromatography to check on plasma levels as often as several times daily. Diurnal variation of plasma drug concentration was so slight as to make apparently unnecessary a customary midday dose of drug. But children tended toward lower plasma levels with an equivalent dose of drug than did adolescents or adults.

And when Dr. Sherwin compared plasma drug levels with adequacy of attack control, he found that more than 90 per cent of patients under complete control had drug levels greater than 40 micrograms per ml. There was no correlation between plasma levels and clinical side effects of the drug.

In a score of uncontrolled patients, when the dosage was raised enough to bring plasma levels above 40 micrograms, more than a third were brought under complete control and nearly that many had only infrequent attacks.



"I flunked health education."



by Olden

Congress Asks Drug Agencies For Research Approval Data

Continued from page 1

sol and FDA Commissioner Dr. Charles C. Edwards that procedures for clearing research applications will have to be "speeded up."

The lawmaker's rebuke to the officials came in separate sessions after each had testified on problems of amphetamine control. Mr. Rogers said that his concern was prompted by reports that qualified investigators were encountering exceptional delays in getting approval of their projects and that the BNDD was imposing, in some instances, inexplicable requirements for safeguarding drugs.

He cited a report that investigators had to have a 750-pound safe in order to store as little as 1 Gm. of marijuana.

Of further concern, said Mr. Rogers, is the fact that it has become unclear just how the BNDD and the FDA are dividing their respective responsibilities in dealing with proposed research protocols, although the mandate of the 1971 omnibus drug bill is precise. Under that measure, the authority for reviewing the scientific merits of a research protocol is vested in the Department of Health, Education, and Welfare.

Opposed by Justice Department

This feature of the bill was passed over the strong opposition of the Justice Department, which sought to maintain substantial scientific review authority over research within the BNDD.

Recently, 101 scientists, including three Nobelists, have protested to President Nixon that the Justice Department has, in effect, been seeking to regain that authority through a variety of legalisms. The scientists, acting under the sponsorship of the Committee for Effective Drug Research, charged that the BNDD has issued "rules, regulations, statutes, procedures, and legalisms" that create "barriers to research and threaten the continued existence of research itself (MEDICAL TRIBUNE, February 23).

Both Mr. Ingersoll and Dr. Elmer A. Gardner, director of FDA's Division of Neuropharmacology, acknowledged to the subcommittee that there have been problems in speeding approval for research projects. But they insisted that these occurred in the early months after passage of the bill and that swifter procedures are under study and will be put into effect.

Mr. Rogers pressed the officials for answers to the question of who is exercising the final authority for approving a research project.

"The Congressional intent in framing the 1971 drug act," he declared, "was that the FDA and HEW would approve drug research. We're getting feedback that

this is not working out as intended."

As a result, he declared, one major mental health institution has "stopped all research on new compounds." In another case, he said, a leading investigator reported that "FDA would not approve a research project without BNDD approval and the BNDD said it would not approve without approval from the State Narcotics Commission, and the state said that it would not approve without the FDA's approval."

If the states do, in fact, demand the right to approve drug research, Mr. Rogers added, "perhaps there should be Federal pre-emption in this matter."

Mr. Ingersoll denied that the BNDD is seeking to exert authority over the scientific end of drug research.

"When we receive these requests [for drug research approval] we pass them on to the FDA immediately," the Justice official stated. "The merits of the research are passed on by the FDA. We're not getting into the scientific end."

He told the subcommittee that the BNDD plans to prepare a single research registration form and one order form for drug supplies and that it will develop procedures so that "the first research protocol will be enough to get them [the investigators] registered and they'll not be required to re-register."

The ire of scientists working with psy-

chotropic compounds has been especially provoked by the current rule requiring them to fill out a separate registration form for each new project.

Mr. Rogers commented that he hoped that procedures could be "speeded up" and added: "The scientific community is concerned about this and legitimately so."

This led to a sharp exchange with Mr. Ingersoll.

"We've been the brunt of scientific criticism for a long time," Mr. Ingersoll declared. "We have no desire to impede scientific research and no desire to have anyone take potshots at us."

"Nobody is taking potshots at you," Mr. Rogers retorted. "I'm not... yet. These protocols under law must be approved by the FDA, not you."

He repeated his request: "Let us know for the record how long it's been taking research to get approved."

In his discussion with Dr. Gardner, Mr. Rogers again brought up the issue of who was approving what.

"The Bureau of Narcotics and Dangerous Drugs is not supposed to give approval to drug research," he declared. "What's happening?"

"We look at the protocol and determine if it's satisfactory," said Dr. Gardner.

"I understand they have to send through the BNDD before going to you. Is that true?" the lawmaker asked.

"At first, but not now."

He told the subcommittee that the "maximum time" for review and a decision on a research protocol has been two months.

Vein Bypass Graft May Be Helpful In Some Anginas

Continued from page 1

original episodes, the cardiologists said. Two of the four had myocardial infarctions after discharge.

Prior to surgery, five patients had onset of an anginal syndrome within one month of admission, 21 presented with stable angina of one-month to 12 years' duration that had become crescendo in character in the weeks prior to admission, and two had a background of stable angina and had developed either nocturnal angina or angina decubitus in the month prior to admission.

All Had Abnormal ECGs

All patients had abnormal electrocardiograms, and coronary arteriography most commonly demonstrated impairment of all three coronary arteries. Left ventricular angiograms showed areas of akinesis or dyskinesia in an area of the left ventricle supplied by the diseased vessel in 16 of the 28 patients.

Six other patients who met the criteria for impending myocardial infarction were not operated on. Two developed ventricular arrhythmias refractory to medical management and died in the hospital. Another, aged 74 years, responded to propranolol and was not studied further because of his age and died suddenly, of a presumed myocardial infarction, six months later at home.

The three survivors who were discharged without surgery were followed for an average of five months, and all continued to have incapacitating angina and are currently being considered for selective bypass surgery.

It is difficult to decide whether the aggressive surgical approach taken towards the 28 patients with impending myocardial infarction resulted in acceptable mortality and morbidity, the cardiologists said.

Prior Studies Have Varied

Prior clinical studies have varied in their definition of impending myocardial infarction, making comparison between patient groups difficult, they pointed out. Additionally, they said, the natural history of impending myocardial infarction, which is "the final marker against which any therapeutic approach must be measured," has not been well described.

"Only careful study of large groups of patients, with angiographic correlations and long-term follow-up, will clarify what happens in time to the patient with an impending myocardial infarction," they emphasized.

Certain data that are available, however, suggest that these patients have a substantial chance of dying from a fatal myocardial infarction if treated conservatively and that a substantial percentage of nonfatal infarctions may be prevented by surgery.

In addition, the team asserted, it seems unlikely that the incidence of relief from angina obtained in their operated patients could be expected with conservative management.

To predict the financial future we don't use a crystal ball



We use Eliot Janeway as our economic analyst, and it's he who wrote:

August 31, 1970

... Analytical realism calls for a new look outside the economy and outside America to the war storm centers to the Far East and the Middle East. Political and military developments seem to be more likely to write the history of the markets next year and the year after that than economic or even financial developments.

Nov. 30, 1970

If I am right in expecting 1971 to be a year of major disappointment—in the first half for the stock market and for corporate earnings and in the second half for the American economy against a deteriorating international background—the way to watch the political fistclenches in Washington from now to the end of this calendar year is as the pattern-setting prelude to the fiscal period running from July 1, 1971, to July 1, 1972. The financial...

March 3, 1971

How long the consumer will remain a bargain buyer, because a cash saver, depends upon the answers to the more fundamental question: How long will the consumer be plagued with doubts and fears about the security and continuity of income? To ask the question is to answer it. No consumer bail-out for business will be in the cards so long as unemployment is in the headlines. But unemployment will be so long as the Administration believes itself with the theory that business's problem with labor is not its business. Business's hangup over labor is responsible for it.

August 4, 1971

Time is running out on the recovery premise in the economy even faster than it is running out on the premise of a bull market renewal in the stock market. The indigestible practices of accounts receivable financing, and producer-inventory accumulation, are the current casualties of this disillusionment. A spate of bankruptcies for businesses passing as solvent but not liquid will be next.

Oct. 6, 1971

The softening economy is still softening—and not just inside America. In fact, the slowdown is proceeding at a faster rate in strong foreign economies than in the American economy. Understandably so, because it has further to fall in the Germans, Japanese, and Austrians. To take one example, the aluminum production cutbacks announced in Australia are radiating shock waves in Japan, whose materials buying rate in Australia has been the measure of the growth rate to both these pace-setting economies. Such is...

Medical Tribune readers expect and get clear, hard-headed reporting and analysis—whether the subject is medicine or economics.

EPIDIOGRAMS—Clinical and Otherwise

To be right before the right time is heresy, which is sometimes paid for by martyrdom.

Santiago Ramón y Cajal
Charles de Caffe

Drug Abuse by Youths Said to Be on Increase

Medical Tribune Report

OTTAWA—An increasing number of children, adolescents, and young adults from all socioeconomic levels in North America are succumbing each year to the "lustre of a chemically induced paradise," Dr. Frank J. Ayd, Jr., of Baltimore said here.

Dr. Ayd spoke on drug abuse at the 25th World Medical Assembly of the World Medical Association.

Polyabuse is now common, with stimulants, depressants, and hallucinogens being consumed in sequence or combination, he said. The current favorites are heroin, marijuana, hashish, LSD, amphetamines, especially methamphetamine, and short-acting barbiturates.

Psychiatrists also are seeing more and more apathetic, academically impaired young people without ambition or social interests and a history of several years of drug taking, Dr. Ayd said.

In the current upsurge of drug abuse the age of commencement of drug taking has been dropping from the upper to the lower teens and even into the preteens.

The very young, ages six to 14, are almost exclusively sniffers or cough syrup drinkers, he said. They are inhaling glue,

gasoline, cleaning fluid, lighter fluid. Some of the more venturesome are whiffing the freons used in carriers in aerosol sprays, such as insecticides and deodorants.

Among those aged 15 to 19, there is an increase in the use of marijuana and hallucinogens, he said. More are turning to heroin and morphine.

In the 20-to-24 age group, initiates invariably smoke marijuana and occasionally take psychedelics, most often LSD. Novices and even established abusers often mistakenly believe they are not consuming the LSD they want to avoid for fear of its publicized adverse effects—chromosomal aberrations. They think they are ingesting nescaline or psilocybin.

Men Seek Instant Pleasure

There is a shift in the sex ratio of abusers after age 25, Dr. Ayd noted. The number of women drug users rises. "Men prefer drugs that produce instant pleasure," he said. "Women more frequently become hooked on prescribed drugs acquired from one or more doctors. Some dislike their need for a sedative or stimulant but persist with their abuse because withdrawal effects are so unpleasant. Other women taking increasing doses, particu-

larly of stimulants, because they like to be energized and euphoric."

The excessive use of stimulant drugs, particularly the amphetamines, has changed dramatically and drastically in recent years, Dr. Ayd said.

"The rate of drug abuse skyrocketed in the early 1960s. Value systems were changing. . . . Young people became interested in the amphetamines. They promptly learned that these compounds could produce an ecstatic 'high.' Each year the increment of those submitting to the enticement of 'speed' has risen. They are pillily seek the instant superlative experience and the series of orgasms 'Dionysus' swift impact on the midbrain injected 'speed' provides."

Barbiturate and nonbarbiturate sedatives and hypnotics are being abused to a lesser extent at this point, he reported, than stimulants.

The curve of marijuana use has been rising steeply, however, he said. Severe penalties and frequent arrests have not discouraged millions of Americans.

Meanwhile, the increase in heroin addiction rises steadily, he said, among not only ghetto residents but also middle- and upper-class people.

Adjuvant-Induced Arthritis Curbed In Rats by Prostaglandin Injection

Medical Tribune Report

NEW YORK—Injections of prostaglandin E effectively prevented or suppressed adjuvant-induced arthritis in rats, Drs. Robert B. Zurier and Fronco Quagliata, of the New York University Medical Center, told the 35th annual meeting of the American Rheumatism Association here.

A severe and persistent polyarthritis appears to rats 10 to 14 days after a single intradermal injection of Freund's complete adjuvant, they said, providing a convenient model for evaluation of anti-inflammatory and immunosuppressive drugs.

Rats injected with 500 micrograms of prostaglandin E₁ twice daily for 21 days from time of adjuvant injection showed little or no arthritis, however, while severe polyarthritis developed in all rats that were given bovine albumin or prostaglandin A₂ following adjuvant injection, they reported.

Identical doses of prostaglandin E₂ also prevented arthritis from developing, they said. Nor did arthritis appear in rats observed for six weeks after prostaglandin E₁ treatment was stopped.

Rats receiving prostaglandin E₁ also

had a less intense inflammatory response than controls at the site of adjuvant injection, the physicians said. In addition, they were more active and were spared the weight loss, leukocytosis, and anemia characteristic of the disease. Numbers of circulating lymphocytes were not diminished by prostaglandin E₁ treatment.

Other groups of rats received a similar 21-day course of prostaglandin E₁ beginning seven, 14, and 21 days after adjuvant injection. Those treated from day seven showed little or no arthritis. When treatment began on day 14, the typical explosive course of the arthritis, which had already started, was suppressed, and established inflammation was reduced even when treatment began on day 21.

Delayed hypersensitivity reaction was determined by skin testing with purified protein derivative in adjuvant-injected rats after 14 days and was positive in all rats, including those completely protected from arthritis. Erythema and induration were greater and more persistent in treated rats than in controls.

To further assess immunologic compe-

tence, rats were given washed sheep red blood cells intraperitoneally on day 14. Seven days later, the rats were bled and the brisk antibody response to the sheep red cells in control animals was markedly reduced in animals treated with prostaglandin E₁.

Humoral Immunity Impaired In Rheumatoid Arthritis

From Toronto and Glasgow, Scotland

► An impairment of humoral immunity, in addition to impaired cellular immunity, may contribute to the higher rate of infections in rheumatoid arthritis patients, according to Drs. Waldemar Pruzanski and Wolf D. Leers, of the Wellesley Hospital, Toronto, and A. C. Wardlaw, Ph.D., of the University of Glasgow, Scotland.

Rheumatoid synovial fluids were tested and found to have a much weaker bacteriolytic action than rheumatoid sera from the same patients, they reported. Rheumatoid synovial fluids were also much less active bacteriolytically than those from osteoarthritis patients, which in turn were less active than osteoarthritis sera.

Forty per cent of rheumatoid sera tested had lower bacteriolytic activity than sera of healthy subjects, but bacteriolytic activity was normal in both rheumatoid and osteoarthritis sera, the investigators said.

SURGICAL NOTES

Total Hip Replacement

SAN FRANCISCO—The increasing use of total hip replacement surgery should not influence clinicians to lower the age level of patients chosen to receive it, Dr. John Crawford Adams, orthopedic consultant, St. Mary's Hospital, London, warned.

Speaking on surgical treatment of the painful osteoarthritic hip, he declared that the practice of operating on patients age 60 or over should be maintained whenever possible.

"What we have to realize is that a total replacement arthroplasty, even the best one, does not restore a normal hip," he said at a meeting of the American Academy of Orthopedic Surgeons. "If a young patient were to attempt to lead a vigorous life, including sports, dance, and other strenuous activities, he would quickly break down the new joint."

However, Dr. Adams said, if there is some other factor in the case of a younger person, such as multiple joint invasion, that would anatomically curtail his activity, the operation is one that is worth contemplating.

Total hip replacement was described by Dr. Adams as "the outstanding event in orthopedic surgery in the last decade."

Still, he cautioned, there are a number of unanswered questions about the procedure. For example, if the prosthesis moves, the plastic may flake off and may promote a foreign-body reaction. Also, methyl methacrylate may not be the final answer as cement.

Infants' Cardiac Defects

MELBOURNE, AUSTRALIA—About 80 to 85 per cent of all congenital cardiac defects in infants under one year of age could theoretically be improved by expertly performed and properly selected operations, it was suggested at the International Cardiology and Cardio Surgery Conference.

Dr. Dan G. McNamara, director of pediatric cardiology at the Texas Children's Hospital, Houston, said that the outlook is contingent on accurate diagnosis of the anatomic defect and identification of the type and severity of hemodynamic dysfunction. Surgical success is also dependent on expertly administered anesthesia, he added.

The quality of early postoperative cardiac and ventilatory care can complete or prevent a successful surgical result, Dr. McNamara said.

Doubts on Vein Graft

MONTREAL—Enthusiasm concerning the aortocoronary vein graft procedure has been dimmed here by the disturbing number of occlusions and stenoses found during follow-ups at the Montreal Heart Institute.

The findings have led heart specialists at the institute to conclude that the procedure will require "extreme selection in patients" in the future.

Dr. Martial Bourassa, cardiologist, and Dr. Lucien Campeau, chief of the department of medicine, said they now feel that the aortocoronary vein bypass should be restricted to patients with incapacitating angina and with relatively poor prognosis. It should not now be used for treating heart failure, they said, except perhaps those almost always fatal cases occurring in combination with cardiogenic shock, when it would be used as an emergency procedure.

Rejoining Severed Fingers

SYDNEY, AUSTRALIA—A plan for greater awareness among doctors of the possibilities of rejoining severed fingers was made by Dr. P. Tomlinson, of Prince of Wales Hospital.

"Hands and fingers are still being lost because hospital casualty doctors do not realize they can be saved," he said.

Dr. Tomlinson reported that he has carried out 20 successful operations of this type to date.

Treatment for Infertility

TOKYO—High dosages of human chorionic gonadotropin administered to 30 infertile oligospermic men were followed by pregnancies in one-third of their wives, according to a report to the seventh World Congress of Fertility and Sterility.

The men, patients of the Margaret Sanger Research Bureau of New York, received 10,000 I.U. of HCG intramuscularly twice weekly for 10 weeks, Drs. Jeanne A. Epstein, Aquiles J. Sobrero, and Shlomo Bichacho said.

None of the patients had hormonal or testicular biopsy evidence of primary testicular failure, according to the report.

Two of the 30 men showed improvement in semen quality and one showed equivocal improvement. Of the 10 pregnancies, however, nine were in wives of men without semen improvement.

Toxic Infectious Shock

VIENNA—Treatment of toxic infectious shock that includes intravenous supply of fluids, digitalization, and administration of vasodilators has had favorable results in a series of patients at the Lelden University Hospital, it was reported here at an International Congress of Infectious Diseases.

Prof. W. R. O. Gossings, of the Academic "Ziakenhuis" of Lieden, the Netherlands, said that only one of 16 patients treated died in shock. Seven of the remaining 15 died from a few days to several months later because of "continuing infection, other postoperative complications, or the severity of their basic disease," he said.

"This might indicate that, besides microbial infection, host factors also play a role in the occurrence of septic shock," he commented.

Determining Drug Effects

STOCKHOLM—The steady-state plasma level of a drug that is metabolized is generally a more important determinant for its effect than dosage because it reflects the amount of drug available for biologic action, Dr. Folke Sjoqvist, Professor of Clinical Pharmacology at the University of Linköping, said at a symposium on pharmacokinetics and therapeutics.

He listed three prerequisites for correlated pharmacokinetics and pharmacodynamic studies in man: the availability of sensitive, rapid, and selective analytic techniques; certain characteristics of a drug, such as its acting reversibly or independently, and having so-called steady-state kinetics and roughly the same degree of protein binding over the entire range of therapeutic plasma concentrations; and availability of quantitative methods for recording the pharmacologic effects.

Thymus, Cancer Research

SYDNEY, AUSTRALIA—Closer analysis of the functions of the thymus gland may reveal some new avenues of research on cancer treatment, Dr. Malcolm Trill, a Melbourne pathologist, told the Australian Cancer Society.

He postulated that there may be a connection between the interaction of the medulla and the cortex of the thymus and the form and time of onset of diseases.

"The medulla aids immune development—a suggestion already supported by some experimental evidence—and the cortex may aid tolerance to 'foreign' substances in the body," Dr. Trill said. "The incidence of diseases such as leukemia, intrinsic asthma, and purulent streptococcal disease is high in the age period one to four years, and malignancy is high to the old—stages in which the cortex is predominant. However, in the elderly the picture is modified by the falling off of the total thymic function, despite the cortex predominance."

When diarrhea wrings the wedding belle...

It's all very well to counsel patience in diarrhea patients. There are times when relief of symptoms can't come too soon.

X-ray studies in 16 normal subjects showed just how promptly the active ingredient in Lomotil does its work.

Lomotil retarded gastrointestinal motility particularly during the first three hours after administration. It continued its moderating action on the bowel for at least three hours more.

Physicians prescribe Lomotil more often than any other drug when the urgency for the control of diarrhea is most distressing.

Lomotil

TABLETS/LIQUID

Saves the Day

When a patient is suffering from diarrhea, the urgency for relief is often great. Lomotil (diphenoxylate hydrobromide with atropine) is a powerful antidiarrheal agent that provides rapid relief of symptoms.

Lomotil is indicated for the treatment of acute and chronic diarrhea. It is also useful in the management of irritable bowel syndrome. The active ingredient, diphenoxylate hydrobromide, acts on the smooth muscle of the gastrointestinal tract to reduce motility and increase the tone of the internal sphincter.

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LOW PRICE
33%
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Polycillin
(ampicillin trihydrate)
the most frequently prescribed brand of ampicillin

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The Machine

On the one hand, the Department of the Navy tells us that, "contrary to the fears of some that computers will eventually make all our decisions for us, the Navy is taking the approach that computers can best be used as an aid to human judgment in making a complex decision." On the other, United Press International reports that "a scientist at the Massachusetts Institute of Technology believes that within eight years a machine with more intelligence than the genius level will be developed, but he wonders if man can control it."

Whether we control the machines or the machines control us, language is going to be one of the major problems of whichever master-slave relationship develops.

Take the language used by computer people to communicate, if that's what they are doing, with one another. We have at hand a release from a California outfit touting a new storage system named Cal-Comp 1144 DSS that "is both plug-to-plug and program compatible with FASTRANO." We think that FASTRANO is a rival system, for the release goes on to say: "Users have reported gains of 100 per cent in peripheral throughput compared to FASTRANO II."

But if people are having trouble communicating with one another about machines (peripheral throughput, forsooth!), their problem is minute compared to what lies ahead for the machines when they try to communicate with one another. A veritable Tower of Babel has already been built, and it looks as if the great computer world of the future is going to need more simultaneous translators than the U.N.

"Though Algol 60 may represent the epitome of the near-perfect programming language, PL/I ('designed by a committee, without benefit of academic insight') is emerging as the lingua franca for computers—because IBM says so," reports *New Scientist*, in a piece dealing with this very problem.

The article names six other languages already "most popular" among computer programmers: Cobol, Fortran, RPG, Basic, APL, and Algol. As far as we can make out, a Cobol-chattering computer can't relate to one that speaks Algol; indeed, *New Scientist* refers to one computer as a "Cobol-cruncher," which scarcely suggests an amicable language relationship.

PL/I a lingua franca? We have a release here from a corporation in Massachusetts bursting with excitement because it is going to help pathologists by means of a new, special computer language named LABTRAN.

"The patient disclosed that she also carried half a pill in her purse, which she seldom used, but felt great security just knowing it was there. This pill was found to symbolize her illusory penis."

—*Summaries of Scientific Proceedings*, fall meeting, American Psychoanalytic Association.
Only half a pill? She some kind of castrator or something?

"By the same token it is rude and insensitive to ask the type of how-come question ('How come you burned the toast?') which is both an accusation and a demand that the other person defend himself. Before asking any question one should think whether it can be answered at all or whether the one who replies will just lose face."

—*Arizona Medicine*.
Well, how about this more impersonal question: How come that parenthesis was never closed?

Readers are invited to contribute items of 100 words or less to this column. Contributions should be mailed to MEDICAL TRIBUNE, 110 East 59th St., New York, N.Y. 10022.

Medicoeconomics

Hospital Association Votes 'Financial Requirement' Curb

Medical Tribune Report

WASHINGTON—For the first time in its 74-year history the American Hospital Association has voted to put a ceiling on the "financial requirements" that are needed to keep hospitals in operation.

As part of a push toward a more uniform nationwide scheme of fiscal accountability in hospitals, the A.H.A. also said it will propose Federal legislation to put hospital income under the rule of state commissions, much as public utilities are regulated now.

Both of the moves brought some dissent from the 139-member House of Delegates at the association's annual meeting here, but the majority responded in accord with the "urgency" emphasized by the chairman of the A.H.A. financial council, whose report brought the matters to a vote.

The chairman, David H. Hitt, of the Baylor University Medical Center in Dallas, Tex., said that both government and other payers of health care costs regarded it as a "blank check" with no explicit limit or ceiling on the amount of money that hospitals need to conduct the business of health care.

"A Test Of Reasonableness"

The limit that the delegates ultimately approved, Mr. Hitt said, constitutes "a test of reasonableness of total financial requirements" of a hospital.

Although several rate-setting mechanisms for hospitals exist other than a state commission, he said, the "realities" include the fact that some states already are moving into hospital rate review. For instance, a voluntary board of hospital, physician, insurance, and public representatives "has appeal" as a way to establish hospital rates, Mr. Hitt believes.

But the circumstance that six states already have enacted hospital rate review laws and three more have such legislation pending is a strong indication that something more than voluntary committee control is wanted in parts of the country.

The central problem that started Mr. Hitt's council working on the financing matter two and a half years ago, he explained to the delegates, is that the growth of third-party payers—government, insurance, or whoever—in the health care system has shown a "great need for the prospective determination of hospital rates." It is no longer feasible, he said in an interview, to rely on retrospective reimbursement to hospitals, adjusting the apportioning of the costs long after the service has been delivered.

Inadequacies of retrospective reimbursement are glaringly apparent, for instance,

in the Medicare program, he said. Some hospitals have still not closed out their accounts with the Government for 1966-67, the first year of Medicare.

The "test of reasonableness" that the delegates approved, after more discussion than was elicited by any other item on the agenda, reads like this, in part:

"To limit the total allowable financial requirements... to traditional accounting expense (excluding explicit interest), plus an overall rate of return on total assets employed in providing institutional health care services."

Translated from accountant's language, Dr. Hitt said later, the formula means that income has to cover "everything necessary to operate a hospital," plus paying off its long-term indebtedness, plus replacing its facilities, plus keeping it in a financial shape to borrow money for necessary expansion.

The "rate of return" brought several questions from delegates, including one who said he was "confused" because "a rate of return is a profit in the public utility sense. Are we saying that hospitals should have a profit?"

"No," Mr. Hitt explained; "we're saying that hospitals should have their 'financial requirements'."

Another delegate saw ambiguity in "rate of return." Mr. Hitt pointed out that "levels of rates of return already exist in every state for public utilities. We see no problem in states' arriving at a rate for the hospital industry and still allow it to attract capital funds."

Unwilling To Wait Longer

The urgency that Mr. Hitt attached to approval of the rate-limit and regulatory issues was explained by him as an "unwillingness" to wait until the next meeting of the delegates in six months. "The life span of Phase Two [of the Nixon administration's economic control program] and the future prospects of H.R. 1 [the successful-looking bill to revamp Medicare and Medicaid] could make six months seem like a long time," he said.

The matter of urgency was further clinched by the view of Gordon R. Cumming, California delegate from Sacramento, who thought "this action could well have been taken a couple of years ago in our own best interest." And the new A.H.A. president, Stephen M. Morris of Phoenix, who said, "We probably are two or three years late in coming forth with guidelines that give us some protection. However, there is a *quid pro quo*; we have to give something for the protection—thus the limit on financial requirements."

Immunologic Study



Immunologic studies focusing on developing agents that may be used in controlling certain allergic disorders, transplantation rejection, and cancer are being pursued by Dr. Claude Bennet, University of Alabama in Birmingham. Dr. Bennet loads samples for amino acid analysis.

A.H.A. Heads To Leadership In Health Field

Continued from page 1

National Council of Senior Citizens, acknowledged that his committee included members "occasionally critical of health care and hospitals."

The association's attitude helps make it logical that the A.H.A. should play the "leadership role in the development of national health policy," he said, because "the organized medical profession will not provide positive leadership but will continue to fight rear-guard action."

The place for physicians in all this leadership was spelled out in another report to the delegates by Dr. Thomas H. Ainsworth, Jr., chairman of the A.H.A. Committee on Physicians.

"A more effective role for trustees and medical staff in the A.H.A. structure and programs... would increase the credibility of the association as a spokesman for the health care field," Dr. Ainsworth said.

The participation of medical staff particularly is needed to aspire to the other goals set by the physicians' committee: (1) the formation of ambulatory care centers as an alternative to emergency departments, (2) the development of the "health maintenance organizations" that are hospital-based, and (3) the development of "quality assurance programs... to bring the nuclei of the office practice of medicine into the same organizational structure as the hospital."

Daylong Janeway Seminar Set for N.Y.C. March 9

NEW YORK—The Federal budget crisis and its effect on the economy and the securities markets will be the theme of the March 9 Janeway Seminar. Guidelines for decision making by money users will be its aim. The daylong meeting will be held at the New York Athletic Club.

Sen. Stuart Symington, who has just returned from a tour of Asia and the Mediterranean, will be the luncheon speaker. His topic is "America's Overseas Commitments."

Albert Sindlinger, well-known analyst of consumer confidence, will update his continuing study of political, investor, and consumer reaction in the morning session. Edoan Gould, editor of *Findings & Forecasts*, will discuss "Measuring Stock Market Strengths and Weaknesses" in the afternoon.

Elton Janeway will serve as master of ceremonies and will lead the discussion. Admission is by advance registration through Janeway Publishing & Research Corp., 15 East 80th Street, New York. Single admission is \$250, and additional participants from the same organization may register for \$100 each.

MEDICAL MEETING SCHEDULE

Domestic Meetings

- Apr. 3-8 ... American College of Radiology, Miami Beach, Fla.
- Apr. 3-8 ... American Association of Anatomists, Dallas, Tex.
- Apr. 4-6 ... American Association of Planned Parenthood Physicians, Detroit
- Apr. 6-8 ... American Society of Group Psychotherapy and Psychodrama, New York
- Apr. 6-12 ... American Leprosy Mission—U.S. Public Health Service Hospital, Seminar on Leprosy, Carroll, La.
- Apr. 7-8 ... American Burn Association, San Francisco
- Apr. 10-14 ... Federation of the American Societies for Experimental Biology, Atlantic City, N.J.
- Apr. 13-18 ... American Dermatological Association, Dorado Beach, Puerto Rico
- Apr. 14-15 ... Allen O. Whipple Surgical Society (sponsored by the Department of Surgery, Yale University), New Haven, Conn.
- Apr. 14-16 ... American Society of Internal Medicine, Atlantic City, N.J.
- Apr. 14-16 ... American Psychosomatic Society, Boston
- Apr. 16-19 ... New Medical Executives Conference, Chicago
- Apr. 16-19 ... Cili Memorial Hospital Spring Congress in Ophthalmology and Otorhinolaryngology and Allied Specialties, Roanoke, Va.
- Apr. 16-20 ... American Association of Neurological Surgeons, Boston

- Apr. 16-30 ... International Medical Association, Philadelphia
- Apr. 17-19 ... Society of Air Force Clinical Surgeons, Miami, Fla.
- Apr. 20-21 ... American Association of Railway Surgeons, Chicago
- Apr. 20-22 ... American College of Surgeons, Illinois Chapter, Fort Hayes
- Apr. 22-26 ... American Society of Abdominal Surgeons, Chicago
- Apr. 23-24 ... A.M.A. Congress on Environmental Health—Housing and Health, Los Angeles
- Apr. 23-24 ... American Otolaryngological Society, Palm Beach, Fla.
- Apr. 23-26 ... Arkansas Medical Society, Hot Springs
- Apr. 23-29 ... International Congress of Cardiology (sponsored by International Society of Cardiology and hosted by American Heart Association, the California and San Francisco Heart Association and the California and San Francisco Heart Associations), San Francisco
- Apr. 24-27 ... American Academy of Pediatrics, San Diego, Calif.
- Apr. 24-28 ... Association for Research in Vision and Ophthalmology, Sarasota, Fla.
- Apr. 26 ... Association for the Advancement of Psychoanalysis, New York
- Apr. 26-27 ... American Society for Head and Neck Surgery, Palm Beach, Fla.
- Apr. 26-29 ... West Virginia Academy of Ophthalmology and Otolaryngology, White Sulphur Springs